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HSJ

World rankings mean nothing **SIMON STEVENS: 14**

Get patients on their feet **RESOURCE CENTRE: 22**

Trusts contemplate effect of tariff cuts **NEWS: 4**

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VITAL SIGNS

WHAT ALL FOUNDATION TRUSTS MUST LEARN FROM THE FTSE 100: 20-21

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¤Green Fleet car manufacturer of the year 2007/08. †Depreciation allowance against profit, 100% for vehicles emitting below 110 (g/km) CO_2, 20% for vehicles emitting 110–160 (g/km) CO_2.

EDITOR'S CHOICE

NEWS

'The system has to reduce cost without shifting it to one side'

Hospitals are likely to face a cut in income next year as the government caps the number of patients they can be paid for in full under payment by results.

Page 4; leader, page 3

RESOURCE CENTRE

The furore around allegations of bullying by NHS East Midlands demonstrates the importance of making senior managers more aware of the impact of their behaviour. Also in Resource Centre: exploring options for funding new equipment.

Starts page 19

NEWS ANALYSIS

The Conservatives have stuck boldly to their core promises to deepen Blairite reforms of public services. But confusingly they have spent as much energy opposing change as they have advocating it. Andrew Haldenby of the think tank Reform looks for clarity in the Tories' sometimes murky vision.

Page 12

HSJ's Leadership Forum 2009 is in London on 30 November, www.hsj-forum.com

OPINION

'No other nation faces the challenge of organising healthcare for 300 million people. Try designing a system for Spain, Germany, Britain, France, Poland and the Netherlands'

Simon Stevens

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BLOGS

'Griffiths had wanted doctors to be central to the new system, but this was seldom the case'

Geoffrey Rivett

Geoffrey Rivett continues his look through NHS history with the publication of the Griffiths report in 1983

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HSJ JOBS

12 PAGES OF JOBS BEGIN ON PAGE 27

Salary band 9
starts on page 27
Director of HR and organisational development, Cumbria

Salary band 9
starts on page 27
Chief operating officer, commissioning, Norfolk

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COVER: ALAMY

ACT ON CO2

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LEADER

RICHARD VIZE
EDITOR

PAYMENT BY RESULTS

Tariff cap may limit some trusts' ability to survive the recession

Concrete evidence of the impact of the collapse of public finances on the health service is beginning to emerge.

As *HSJ* reveals this week (news, page 4) the Department of Health is considering capping the number of patients for which a trust is paid the full tariff, and tying any tariff increase to quality and innovation (CQUIN) targets.

The cap is designed to remove one of the major risks for the health economy as the recession hits – acute trusts crippling primary care trusts by trying to grow their way out of trouble through more activity. The fear was that a simple cash cut in the tariff would trigger a surge in hospital procedures.

This move effectively transfers the risk from the PCTs to the providers, but this is a blunt tool.

Making such a drastic change to health funding is an admission that PCTs have failed to get a grip on demand.

Over the last few weeks there has been plenty of anecdotal evidence that many trusts were relying on growing activity to keep their heads above water.

In recent years trust income has had a habit of soaking up all the extra cash flowing into PCTs. Despite all the talk of moving services into the community, demand management and disruptive innovation, it has been business as usual. The price for this is now that some trusts will be at serious risk of getting into difficulty.

'For months Monitor has been spelling out that some foundation trusts have simply not grasped the height of the financial cliff they could fall off'

For months now Monitor has been spelling out in increasingly bloodcurdling language that some foundation trusts have simply not grasped the height of the financial cliff they could fall off. And even many of these optimists are expecting severe staff cuts.

Before long the implications for individual trusts of the new tariff rules will become clear. But in the meantime the onus is on PCTs to demonstrate how they are going to exploit the headroom they have been given to raise their game in managing demand and shifting more care into the community. ●

COMMISSIONING BUDGETS

Hard cash makes Tory policy a soft target

As the Conservatives' policy of handing commissioning cash to GP consortia comes under closer scrutiny, the lack of detailed thinking about how it will work becomes increasingly apparent.

If David Cameron wins the election GPs will manage "hard" budgets, as opposed to indicative budgets for money which at present is still in the hands of the primary care trust.

But the party struggles to explain when and how the consortia would draw down the money, and what would happen to the interest.

The interest could easily equate to tens of thousands of pounds a year for a typical consortium. The Conservatives maintain the money would have to be reinvested in patient care, but this would be all but impossible to enforce and a huge effort to audit.

There are also no guarantees about the wisdom of a consortium's stewardship of commissioning money. Could it be invested unwisely and lost? If GPs are not allowed to invest it anywhere, then why not just give them an indicative budget, as at present?

With up to £70bn of the NHS budget at stake, the Conservatives must explain how this policy is going to work; very few people are convinced it will. ●

NEWS

CONTACT THE NEWS DESK ON
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DH eyes patient cap for new tariff rules

ACUTE FUNDING

Tariff could be tied in with quality and innovation targets

Sally Gainsbury
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NHS hospitals face a limit on the number of patients they will be paid to treat next year, *HSJ* has learned.

The Department of Health is considering capping the number of patients each hospital trust will be paid in full for treating. Patients over the threshold will be paid for at "marginal cost" – for example, at just half the standard tariff price.

HSJ understands the department is also looking to make any increase in the tariff contingent on meeting quality and innovation (CQUIN) targets, rather than simply increasing the baseline as it has done in previous years.

The volume caps are likely to be set at the number of patients the trust treated this year or last. They will mean that although the DH might report a "headline" increase to the tariff of around 1.2 per cent, acute providers could face cash cuts in the average income they receive for each patient.

The move would respond to concerns that any attempt to simply cut tariff prices will be met by a surge in acute activity because primary care trusts have had little success in stemming the increase in the volume of patients treated in hospitals.

A source close to the discussions told *HSJ*: "The key thing people are grappling with is how you give more strength to the commissioning side without allowing commissioners to absent themselves from demand management."

Audit Commission head of health Andy McKeon said research it is due to publish later this year would show acute trust income had risen in line with the increase in financial allocations to PCTs, suggesting very little had been left over to invest in alternative forms of care.

He said: "In setting the tariff you have to take account of the likely growth of activity in the coming year. In 2008-09 the tariff rose by 2.2 per cent, but trust income rose by around 6.5 per cent, which was exactly what PCTs had extra to spend."

'How do you give more strength to commissioners without allowing them to absent themselves from demand management?'

The changes to the tariff are being considered as Monitor this week issued a fresh warning that a number of foundation trusts still had "an unrealistic view as to the extent of the risk and challenges they face".

Earlier this year Monitor asked foundation trusts to revise their "downside scenarios" in light of the deterioration in the public finances.

In a memo issued to foundation trust chief executives, finance directors and chairs this week the regulator said a number of foundations were still "viewing increased activity and payment for this activity as a route to financial mitigation".

Some of the downside scenarios presented to Monitor show foundations running up deficits as their income stagnates.

For example, East Kent Hospitals University Foundation Trust's draft downside scenario – unusually published in its board documents – shows it expects a surplus of £9.6m next year if its income increases by 1.2 per cent. That will reduce to £9.4m if its income freezes. If that freeze continues for another two years, the foundation expects to have a deficit equivalent to 1 per cent of its income by 2012-12, which will double the following year.

A sample of draft downside scenarios seen by *HSJ* shows that even on assumptions Monitor may consider "over-optimistic", most foundations are planning significant cuts in their costs and staffing levels over the next three years.

The trusts' cost improvement programmes are aiming to shave 5-8 per cent off costs every year for the next three to four years – with the aim of saving the £15bn-£20bn the DH has called for up to 2014.

At each organisation chief executives and finance directors have told *HSJ* around two thirds of this will need to come from pay and a reduction in staffing levels.

NHS hospitals are hoping the bulk of the required headcount reduction will come from natural turnover and recruitment freezes.

But some are preparing to announce voluntary redundancy schemes and to opt out of national pay deals and frameworks.

HSJ understands that strategic health authorities are examining the viability of "clearing houses" for NHS staff who have been laid off by hospitals but could be redeployed elsewhere – for example in community services – with the aim of avoiding staff being made redundant, only to be re-employed elsewhere.

IN NUMBERS

1.7%
Baseline increase to the tariff, 2009-10

0.5%
Extra tariff increases in 2009-10, contingent on meeting CQUIN

0%
Proposed increase in the baseline for 2010-11

1.2%
Proposed extra tariff increases for 2010-11, contingent on CQUIN

50%
Proposed "marginal" price trusts will be able to earn on patient volumes over the cap

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PRIMARY CARE 'Hard cash' budget bonus

Tory plan could give GPs interest bonanza

Sally Gainsbury and Steve Ford
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GP practices could earn thousands of pounds a year in interest payments under Conservative plans to turn practice based commissioning budgets into "hard cash".

At present, primary care trusts spend on average £1,600 per head of population. Under Conservative plans to extend the scope of practice based commissioning, the average GP practice with 6,000 patients could be handed a cash budget of around £7m if practices were given responsibility for 70 per cent of the budget.

HSJ has calculated that if just half of that budget was stored for six months of the year in a deposit bank account paying 3 per cent interest, a typical practice could earn an extra £105,000 a year – a sum equivalent to an entire year's pay for an average GP.

Most practices are expected to group together into consortia, covering populations of around 100,000, or 17 average size practices. That could translate into annual interest earnings of around £840,000.

A Conservative spokesman confirmed the party planned to transfer hard cash budgets into consortia bank accounts, but said interest earned could not be taken as profit. He said: "Any interest earned would have to be used to invest in patient care, not for their own profit."

He said the party had yet to decide precisely how and when in the financial year cash budgets would be transferred to GPs.

Public finance experts have questioned how workable the plans are. For example they could involve the Treasury laying out up to 70 per cent of the NHS budget on "day one" of the financial year, as opposed to the current system where PCTs "draw down" funds when they are needed.

That would have implications for Treasury borrowing needs and, after the collapse of the Icelandic banks, there will be concerns about GPs' ability to make wise choices about where to store money.

Jeff Finney, chair of the Institute of Chartered Accountants in England and Wales and director of a GP accountancy service, told *HSJ* practice consortia would need to set themselves up as not-for-profit entities in order to ensure interest earnings were not taken as profit.

The questions over GPs holding their own budgets follow national primary care director David Colin-Thomé's admission last week, revealed by *HSJ*, that efforts to reinvigorate practice based commissioning have so far failed (news, page 10, 15 October). He described the policy as a "corpse not for resuscitation".

Social Market Foundation head of strategic development David Furness said it was time to stop ploughing money into expanding GP commissioning.

Mr Furness said at least £100m had been spent on trying to reinvigorate practice based commissioning through entitlements, and it was time to "turn off this tap".

"Let it work where it is working," he said. "But let's stop trying to drive it from the centre."

He said it was wrong in the current financial climate to place the "onus" for commissioning on those whose primary role was clinical practice, and the role of PCT commissioners should be strengthened instead.

See leader, page 3

What do you think?
Comment on this story at www.hsj.co.uk

'In setting the tariff you have to take account of likely growth of activity in the coming year'

NHS Confederation policy director Nigel Edwards said such clearing houses – which would need to pool or centrally fund the cost of payment protection and retraining – would ideally cover other public sector employers. That would be difficult because of the range of terms, conditions and pension rights that would need to be accommodated.

See leader, page 3

ALAMY

IN BRIEF

QIPP rebranded

The Department of Health is changing the name of the QIPP (quality, innovation, productivity and prevention) initiative to the quality and productivity challenge. In the meantime, national director for improvement and efficiency Jim Easton, who leads the programme, has made a final call to NHS staff to submit ideas on how to make the £15bn-£20bn efficiency savings required in 2011-14 to the "QIPP challenge" mailbox. The deadline is the end of the month. The email address is: QIPPChallenge@dh.gsi.gov.uk

New Barts chief

Peter Morris has been appointed chief executive of Barts and the London Trust. He replaced Julian Nettel as interim chief executive of the trust in March and took up the position permanently last week. Mr Morris was awarded an OBE for services to healthcare in 2008.

Kennedy on GPs

Former Healthcare Commission chair Sir Ian Kennedy is to take over the King's Fund's inquiry into the quality of general practice in England. The inquiry, previously led by King's Fund chief executive Niall Dickson, will report in September 2010.

Mid Staffs pledge

Mid Staffordshire Foundation Trust chief executive Antony Sumara has pledged to adopt a range of security improvements, after the trust breached the Data Protection Act when a member of the HR team transferred personal information about a trust employee to their home computer, including information relating to a previous criminal conviction. The new measures will include rules for staff on transferring personal information in order to work from home.

Joint PCT chief

NHS Salford and NHS Bury have announced Mike Burrows is to become joint chief executive of both organisations for the next six months. Current chief executive Stephen Mills is retiring.

ANNUAL HEALTH CHECK Experts differ over changed indicators

Impact of targets and FTs seen in acute score slide

Charlotte Santry
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The stroke target, winter pressures and the increasing number of foundation trusts are being blamed for the slide in acute trusts' annual health check performance.

The proportion of acute trusts rated good and excellent for service quality dropped by 9 per cent between 2007-08 and 2008-09, while compliance with core standards fell by 14 per cent (news, page 4, 15 October).

Care Quality Commission chief executive Cynthia Bower attributed the decline partly to more realistic self assessments.

Analysis by *HSJ* shows 65 acute trusts received a lower rating for quality of services this year, of which more than half (33) had foundation status.

Birmingham University professor of health policy and management Chris Ham said newer foundations not yet in the NHS "premier league" were spending a lot of time meeting annual health check requirements while having to "jump through hoops" for Monitor.

He said: "There are so many standards and targets trusts have to abide by. In many cases they're failing very narrowly by decimal point failures on targets when their underlying performance hasn't shifted that much."

Winter pressures last year had brought "a real spike" of accident and emergency attendances leading to many trusts missing the four hour waiting time target, he added.

Of the 65 acutes that performed worse this year, 30 moved from excellent to good, 26 from good to weak and three from fair to weak. Four dropped by two grades, from excellent to fair, while two fell straight from good to weak.

The core standards they were most likely to fail included safeguarding children, decontamination, safe use of medical devices, clean, well designed environments and consent.

Worcestershire Acute Hospitals Trust chief executive John Rostill said his trust slid from good to fair despite increasing compliance with the A&E target from 96.5 per cent to 97.6 per cent. He said in previous years the Department of Health had "rounded up" the percentage.

But he admitted: "We've known about it for a year so that's a wimpy excuse."

A shortage of radiologists meant the trust struggled with the two week cancer wait target. It also missed the target for the time patients spend on a dedicated stroke unit.

A DH spokesperson said that assessment was more challenging this year so comparisons with last year had "very limited value". Changes to the indicators and methodology had affected performance on core standards.

But the CQC denied this year's acute assessment was harder, saying indicators had only changed as much as in years in which results improved.

TRUST COMPLIANCE

CQC chief 'will not wade in' on race equalities

Charlotte Santry
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Care Quality Commission chief executive Cynthia Bower has promised not to go "wading in" to trusts that fail to comply with race equality duties.

Speaking at the Race for Health summit in London on Monday, Ms Bower said she wanted to improve race equality in the NHS by working with organisations before using the regulator's new powers to close or fine services.

She said: "If we come in very strongly straight away, the system will close down and try to keep information away from us. We have to look as if we want to be a partner in improvement.

"We have been given these powers. It's incumbent on us to use them very carefully and not go wading in."

She said she wanted to redress the imbalance between those delivering and receiving care, to ensure that relationships were characterised by dignity, respect and personalisation.

Cynthia Bower: "CQC must look like a partner in improvement"

Work such as the mental health inpatient survey would help move the NHS in the right direction, she said, although she admitted the survey had been controversial.

As reported in *HSJ*, some trusts felt the survey glossed over the positive findings and did not adequately explain that response rates in some organisations were relatively low (news, page 9, 8 October).

Ms Bower admitted she had her "wrists slapped" over the survey but said it had been "very powerful".

She called for health service management to become more representative of its ethnically diverse workforce but said that it was not her job to achieve this.

She said: "It's my job to look into my organisation. We can't preach to other people unless we can look inside our own organisation and see it's doing everything it's meant to be doing.

"I think very few of us can look at our organisations and say we're squeaky clean."

Organisations represented at the summit each pledged to take a specific action to improve race equality, ranging from engaging patient networks to introducing diversity champions in the workplace.

COMPETITION Health secretary's letter promises non-NHS providers will be last resort

Burnham extends provider vow

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Non-NHS providers of services will only be contracted as a last resort, the health secretary has assured the general secretary of the TUC.

Following his announcement in September that the NHS would be the "preferred provider" of services, Andy Burnham has written to Brendan Barber promising that where NHS service providers underperform, the primary care trust will work with the provider, giving them "at least two formal chances" to improve.

Even after this point, the health secretary has assured Mr Barber, the PCT will give the NHS provider every opportunity to continue to provide the service if it can demonstrate improvement.

The letter says: "Only if there was insufficient improvement within a reasonable timescale, and the scale of underperformance was significant, would the PCT consider engaging with other potential providers or other solutions (eg franchising).

"If market testing was subsequently pursued, the PCT would be expected to continue to engage the provider and its staff, and give them the opportunity to compete on a fair and equal basis."

The letter to TUC general secretary Brendan Barber said underperforming NHS providers will have every opportunity to continue to offer the service

Mr Burnham assures Mr Barber an almost identical scenario would occur if NHS providers needed to improve services or their capacity; where there was a risk of clinical or financial uncertainty; or where patient choice needed to be increased. Tendering for alternative providers would be a last resort and the original NHS provider "would be able to bid on a full and fair basis".

In contrast, it says where an independent or third sector contract expires, the PCT would tender openly from the outset, giving NHS providers a chance to bid.

Mr Burnham's letter was included as an appendix to one sent by NHS chief executive David Nicholson to all PCT and strategic health authority chief executives last week.

Mr Nicholson said the letter was to clarify how the commissioning process will change in light of the shift in policy.

There will be new guidance to replace *Necessity – Not Nicety*, which was published just five months ago, and the Department of Health will issue a revised procurement guide and "refined" rules for cooperation and competition.

Mr Nicholson wrote: "In addition to the revised guidance, there will be implications for assurance processes, including for world class commissioning and transforming community services."

But he said: "It is too early to tell what these are likely to be".

He added the DH "remained committed" to the establishment of regional commercial support units and the national strategic market development unit and to the participation of independent and third sector providers "where this is the right model for patients".

Primary Care Trust Network director David Stout warned against "inventing new barriers" to commissioning high quality services in the current financial climate.

NHS Partners Network director David Worskett described the policy shift as a "great pity", which risked slowing procurement. He said Mr Nicholson's letter still failed to address whether the "any willing provider" policy had been dropped.

"It doesn't clarify anything at all – it's a thoroughly incoherent bit of policy. I find it hard to see how it helps anyone," he said.

COMMUNITY SERVICES

Recession is a chance for change says tsar

Steve Ford
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The financial squeeze could finally force the NHS to restructure itself around community services, according to national director for improvement and efficiency Jim Easton.

Nearly four years after the *Our Health, Our Care, Our Say* white paper established the principle of moving many services out of hospitals into community settings, Mr Easton described the recession as the "lever" that could kickstart this transformational change.

Speaking to *HSJ* at the Challenge for Community Services conference in London this week, he said: "Bizarrely, the financial challenge we face is a tremendous opportunity because it forces you to deal with structural change.

Jim Easton: "It will be a bumpy ride"

"In a time of growth you can simply keep adding to the current model and not have to change it. We don't have that option so the choice must be to identify the right changes. It will be a bumpy ride," he added.

Mr Easton also highlighted the better adoption of technologies such as telehealth as critically important to improving community services.

He said that for people at home, managing heart failure for example, proven technology already existed that could transform the quality of their lives and reduce cost.

"We need to get serious about identifying and adopting those," he said. "They can put people in control of their own health and release huge amounts of duplication in wasted time from professional staff."

He said in community services, getting technology to unlock quality, professional time and cost was critical and he was "really interested" in people who were ambitious to lead in this.

Technology was one of two high impact changes Mr Easton identified as ways of delivering better services while reducing costs. The other was the NHS Institute for Innovation and Improvement's Productive Community Services programme, also launched at the conference.

It is the latest in the series of programmes that began with Productive Ward in 2008.

Mr Easton said: "The Productive series has been transformational in the acute sector and has every chance of being equally transformational [in the community]. I think it's a really key driver for change."

PA

FINANCE Bill Moyes claims chair's resignation letter is inaccurate

Monitor and outgoing FT chair clash on safety

Dave West
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Monitor has accused the outgoing chair of a troubled foundation trust of inaccuracy, after he claimed the regulator was neglecting patient safety in favour of cost cutting.

Tim Lincoln resigned from Heatherwood and Wexham Park Hospitals Foundation Trust last week after being asked to do so by Monitor.

His resignation comes as the regulator rejected a turnaround plan the trust developed after it emerged it had financial and performance problems earlier this year. It said the trust lacked "board and clinical leadership".

Mr Lincoln claimed in a letter to the trust's governors that Monitor had indicated the trust should make plans "more financially robust by more sharply reducing costs". He suggested this "would introduce more risk to patient safety".

Mr Lincoln said: "After deep reflection, and consultation with experienced colleagues, I have concluded that in our current circumstances I am not comfortable with a more aggressive cost-cutting plan from a patient safety perspective."

Monitor executive chair Bill Moyes responded with a letter to governors on Tuesday insisting its priority was patient safety.

Mr Moyes said Monitor had challenged the trust on whether its plan had shown it "could return to a position of financial health and stability in its current form and [said] further work is required to 'bottom out' some of the assumptions made in it".

He added: "During the meeting with the trust it was Monitor who raised the question as to how the trust board would ensure that in the delivery of its plans patient safety was protected, and expressed some doubts [that] the trust had yet a sufficiently developed system.

"Tim's suggestion that Monitor expected during our meeting and subsequently that actions should be taken to reduce costs more sharply than that shown in the trust's plan, such that patient safety may be placed at risk, is far from accurate."

Mr Moyes' letter added: "I have to refute unreservedly the assessment of the position and the rationale for his resignation that Tim chooses to set out in his letter."

Monitor has appointed Chris Langley as interim chair. It has also told the trust to appoint a new medical director and will require the trust to strengthen its clinical leadership.

Greenwich drums up local celebration

Children enjoy arts and activities organised for local people by NHS Greenwich to celebrate World Mental Health Day this month. As well as hula-hooping and jiving the 'Get Moving, Feel Good' event promoted positive messages about mental health.

48 HOUR WEEK

More rotas given working time rule reprieve

The European working time directive scrutiny panel has recommended a further 73 acute medical rotas be granted derogation from compliance with the 48 hour week, bringing the total to 273.

This second round of rotas – across 38 trusts – follows the 200 rotas recommended for derogation by the advisory panel in June. Around 4 per cent of acute rotas have now been granted derogation until August 2011.

National clinical adviser for the directive Wendy Reid said: "We have always said we would keep the situation under close review and where there is a genuine need for extra time to safely implement the directive we would allow derogation.

However, the Royal College of Surgeons claimed earlier this month that services in trusts reporting compliance with the directive were "being held together by a 'grey market' of doctors willing to covertly break the legislation to maintain care for patients".

A highly publicised survey by the college suggested 43 per cent of surgeons were covering rota gaps in other areas of their trust to keep services running.

NEW HORIZONS

Trusts respond on mental health vision

Charlotte Santry
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Mental health trusts are pressing the government to look at fresh ways of protecting services given predicted activity increases and the lack of a national tariff.

Trusts were responding to the Department of Health's consultation on *New Horizons*, which will frame the next decade of mental health policy.

The Mental Health Network's response also emphasises the need to work with bodies outside the NHS. This could involve improving parenting skills, urban regeneration, employment and educational initiatives.

It says: "We need a fresh way of government approaching the challenge of improving whole mental wellbeing across government. This is not a challenge the Department of Health can deliver on by itself."

Suggestions include giving mental health a high priority in the quality and outcomes framework, improving clinicians' training, direct payments and improving access for minority groups.

South London and Maudsley Mental Health Foundation Trust's response also says value for money could be improved if GPs stopped prescribing antidepressants for mild depression.

Trust head of mental health promotion Tony Coggins told *HSJ* there was a "real danger" primary care trusts facing tough decisions would cut mental health promotion budgets.

Mental health and wellbeing need to be treated as a cross-government issue, he said, but taking resources from mental health problems in a recession and putting it towards wellbeing would be wrong. He said the fact that there would be no national tariff before 2013-14, and the difficulty of measuring the quality of mental health commissioning, left services "vulnerable".

The response states: "There is a risk that mental health services will experience a greater proportional reduction in spending than other services, at the same time as demand increases."

EVENTS ***HSJ*'s conference on Commissioning Mental Health and Wellbeing is on 28 January 2010. For details see www.hsj-mhcommissioning.com**

MICHAEL WHITE ON POLITICS

The line dividing the public sector from the private has been fragmenting for decades. With the election looming I sense this process is facing a new period of instability, a bit like the earthquake fault lines which bring uncertainty to so many parts of the world.

Typical was a *Financial Times* interview this week in which the CBI's new "outsourcing tsar" (you see, it is not just the NHS and Russia that have tsars), a chap called Adrian Ringrose, suggested every form of public service – except maybe the army – should be opened up to market based competition.

Young Adrian runs a support firm engaged in providing military logistics and says US provision is outsourced "virtually to the finger on the trigger".

He is being a bit coy there because huge private US security firms like Blackwater have been controversially squeezing triggers in Iraq for years; one reason for its recent name change to Xe Services LLC, I suspect.

> **"Pressure to privatise will be on the Richter scale"**

All in all, a sinister trend. What has this to do with the NHS? Lots. Outsourcing is already worth £80bn a year, 6 per cent of UK GDP, and employs almost as many people as the NHS. The squeeze on public spending will force the government – whoever wins – to go further, especially if economic recovery is weaker than Alistair Darling hopes.

Think Royal Mail, where (says me) the posties' militant strategy seems as reckless as the miners in 1984 or Fleet Street printers at Wapping in 1986. Don't do it! It blocks unavoidable reform, as the printers/miners did. Now there is too much opportunism about, private firms circling your core business.

The NHS knows this. Rare is the edition of *Private Eye* (certainly not this week) which does not include an attack on the financial burden to weaker NHS trusts of servicing private finance initiative debts to the private sector. I remain to be persuaded that – overall – the initiative is a bad thing, but when I see the *Daily Mail* complain that health trusts are backing the Commissioning Support Appraisals service's efforts to ensure that the National Institute for Health and Clinical Excellence "rations" what the *Mail* calls "lifesaving" cancer drugs, I smell a commercial rat dressed up as a pro-consumer mouse: the pharma lobby at work, Blackwater in scrubs.

Which leads us to Norman Lamb's much trumpeted Freedom of Information discovery that since 2006 the NHS has spent £1.5m getting 3,337 staff private treatment – notably for physiotherapy, mental health counselling and other Cinderella services.

When I spoke to the Lib Dem health spokesman, nice bloke that he is, "Norfolk Lamb" said he "wouldn't criticise any employer wanting to get his staff back to work. But it is a stark demonstration that in certain areas waiting lists still exist – despite the dramatic improvement in access where there have been targets".

Of course, the truth is less stark. The NHS has always used the private sector, just as doctors and other health professionals have long been good Bupa customers and state school teachers often send their own kids elsewhere.

Indeed, a lot of trade unionists have private health insurance; for many years the Manor House hospital in north London existed to look after union members. Hypocrisy? Some people say so. I think not, unless those who use such services in private publicly campaign for their abolition without acknowledging that they don't practice what they preach.

Norfolk Lamb fears the public/private fault line will soon become a San Andreas fault for Andrew Lansley if (Lamb is one of those who says "if") he becomes health secretary in May. He may be a very reassuring figure, but the pressure from the restless right to privatise services will be on the Richter scale.

Michael White writes about politics for The Guardian.

RECONFIGURATION

Trust's controversial changes see success

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A controversial hospital reconfiguration has cut death rates and the time patients are staying in hospital, early figures suggest.

West Hertfordshire Hospitals Trust closed acute services at Hemel Hempstead Hospital, including its accident and emergency department, and opened a 120 bed acute admissions unit at Watford General Hospital.

Planning started in 2003 and, after facing strong local opposition, the unit was opened and old services were closed between February and March this year.

Early figures show the average length of stay has since fallen by 1.9 days to 5.4. Standardised mortality ratio and readmission rates have also fallen.

Acute and emergency services manager Pat Reid said it had so far coped with demand despite the overall reduction in beds.

However, she said: "We are still being cautious – we have to acknowledge we haven't had winter yet."

The acute services have been redesigned to have acute consultants working at the front line every day, with visits by specialists. Patients have been diagnosed and treated faster, requiring fewer beds. Specialist consultants, particularly cardiologists, also visit the unit more regularly in "hit teams".

Ms Reid said: "The whole model of losing [beds] means you have to do something quite radical."

Chief executive Jan Filochowski, who joined the trust in 2007, delayed the reconfiguration after he arrived and decided it had not been properly planned.

He said: "It is about as big a project as there can be in an acute hospital trust. You have to prepare for it properly, resource it properly and be realistic about the timescale."

WORKFORCE

Obstacles compromise careers

Charlotte Santry
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Trusts should make committee nominations more "democratic" and hold meetings during child-friendly hours to allow more women to take part, a government commissioned review has urged.

Organisations should also extend childcare for staff working unsocial hours, according to *Women in Medicine: making a difference*, published last week.

In a foreword to the report, Baroness Deech, chair of the national working group on women in medicine, said there was "worrying evidence of a series of obstacles" in the system for women, forcing them to make career decisions that were "compromises rather than choices".

The report says positions on boards and internal committees should be advertised more widely, with a "transparent and democratic process rather than simply an appointment by nomination".

The Equality and Human Rights Commission should audit the appointments process for all such posts, it says, to assess whether sufficient opportunity has been created to increase access for women.

The report also calls on NHS Employers to draw up guidance on the additional provision NHS trusts should make for childcare allowances for unavoidable unsocial hours of work.

NHS Employers deputy director Alastair Henderson said: "Detailed arrangements for childcare are a matter for local organisations. Of course, it is not just doctors who may have issues around childcare out of hours."

A "good deal of work" had been carried out on the issue, according to Mr Henderson.

Internal committees within NHS organisations require specific membership, he said, adding that selection processes "need to be transparent".

Chief medical officer Sir Liam Donaldson said he welcomed the report and would ensure the Department of Health considered each recommendation before deciding how to proceed.

PERFORMANCE Flu and politics will add to pressure on services

Nicholson warns NHS of nightmare winter ahead

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A combination of winter pressures and swine flu could lead to delayed ambulances and long waits in accident and emergency, NHS chief executive David Nicholson has warned.

He told organisations to improve planning to avoid missing targets and risking added political criticism of the NHS.

Last year the English average A&E waiting time performance between October and March missed the four hour target. That was blamed on increased demand linked to factors including bad weather and infections such as norovirus. Several ambulance trusts missed their 999 response time targets.

Mr Nicholson told the first Ambulance Service Network conference last week: "Over the last few years we have got better and better at [emergency care], though there are still significant pressures and we saw that last year. There were big problems in some areas. We can't get complacent about the way we plan for winter."

He warned that, because of the election, pressure to perform well would be even greater.

Mr Nicholson said: "We know pressure is going to continue this year against a completely different environment, particularly in relation to the kind of scrutiny the NHS is going to get over the next few months for obvious political reasons."

National director for NHS flu resilience Ian Dalton warned it was possible a swine flu peak would be followed by an outbreak of seasonal flu. The NHS must also be prepared for the possible arrival of H5N1 bird flu, likely to be much more of a threat than H1N1 swine flu, he said.

Mr Dalton said: "My assumption must be we all need to prepare for a long winter with a lot of viral disease running on for a significant number of months."

The Department of Health last week published figures showing 999 ambulance service calls have increased by 6.5 per cent so far this year. Growth is faster than in A&E attendance.

Mr Nicholson called for services to work more closely together to keep patients out of ambulances and away from hospital.

Ambulance Service Network director Liz Kendall said: "The system isn't working as well as it should and ambulance services are determined to work with other parts of the NHS to improve it. We need to make it simpler and easier for patients to access care and provide a range of services – including GPs, community nurses, mental health services, falls teams and paramedics – 24 hours a day, seven days a week."

Winning look for cancer care unit

Maggie's Cancer Caring Centre at Imperial College Healthcare Trust in London has won the RIBA Stirling Prize for architecture.

Maggie's chief executive Laura Lee says users value "the homey space", designed by Lord Rogers of Rogers Stirk Harbour + Partners.

SERVICE IMPROVEMENT

Minority of boards put targets before quality

A minority of NHS boards have prioritised targets, finance and governance over other aspects of service quality, the Department of Health has admitted.

Responding last week to the Commons health committee's report on patient safety, published in July, the government acknowledged "a minority of boards, in their focus on national priorities, may have overlooked some aspects of quality which required local attention".

But it rejected the committee's suggestion that NHS boards in general have neglected their duty to "promote tangible improvements in services".

"There have been major improvements in many aspects of clinical quality, which are highly relevant to the patient safety agenda, for instance in vastly improved access to diagnosis and lifesaving treatment," said the report. It added the requirement for trusts and foundation trusts to publish quality accounts from next year will ensure boards focus on quality.

MEDIA WATCH

It doesn't happen often, but this week the intricacies of health policy have made it into the tabloids.

The *News of the World* gave Andy Burnham and Andrew Lansley the opportunity to go "head to head" answering questions from readers. Topics included whether NHS targets are a good idea or distort priorities, whether the NHS "should pay for lifesaving drugs regardless of the cost" and whether GPs should earn six figure salaries "when they work fewer hours and access is worse than ever".

The answers were predictable enough, what was more notable was the level of detail – and animosity – in an accompanying piece by the paper's "insider in the corridors of power" Fraser Nelson (aka the editor of *The Spectator*).

'Andy Burnham was described as football crazy and Andrew Lansley as deathly dull'

***News of the World* readers will no doubt be grateful they can now enter into the "preferred provider" debate with the best of them, but if they were hoping for clues as to which way to vote, they will be disappointed. In answer to his own question about which man would make the best health secretary, Mr Nelson was firm in his conclusion: "neither of them".**

Mr Burnham was described as "football crazy" and accused of "destroying the bold, radical reforms" made by Tony Blair; Mr Lansley was labelled "deathly dull" and criticised for his plans to "lazily hand the keys over to the people causing the problem" (bureaucrats, of course) via an independent NHS board.

But it has not been all bad news in the paper this week. *The Guardian* reported the chief medical officer's warning that the postal strike could delay letters from GPs inviting patients for their swine flu vaccinations. Perhaps it will spur GPs to join most other 21st century businesses and email them instead? Bring on the revolution.

Rebecca Evans

CONSERVATIVE POLICY

Tories need clear vision and a stronger message

The Conservatives have pronounced themselves the party of reform but are too wedded to the status quo. Andrew Haldenby argues they need to spend more energy advocating change

When David Cameron became leader of the Conservative Party, one of his core promises was to deepen the Blairite reforms of public services rather than abandon them.

Of course there was a political subtext; Mr Cameron wanted to present himself as the reforming heir to Blair in contrast to Gordon Brown's reactionary. But the policy was right – to continue the Blairite agenda of public services reform to deliver not only value for money but also social justice (since the monopoly structure of the NHS and state schools had provided the worst results for people on low incomes).

For the NHS, this meant the Conservatives would push forward with greater patient choice based on much better information, with competition between any willing providers and with real power for commissioners to make change.

Much of Conservative policy since then has stayed true to this initial commitment. At some points, they have shown real courage, not least this autumn when health secretary Andy Burnham threw down the gauntlet on competition. The secretary of state's statement that the NHS should be the "preferred provider" of care was a U-turn that made a nonsense of great swathes of policy on choice and market development. It was a transparent calculation to gain some transitory support from certain unions and bodies at the cost of the permanent loss of the benefits that competition would bring.

Shadow health secretary Andrew Lansley resisted temptation and stuck to the basic principle that any willing provider should be able to treat NHS patients. He spelt it out in his party conference speech: "Labour have turned their backs on competition and choice. We will not."

In similar vein, the fringe of the Conservative Party conference heard praise of NHS Great Yarmouth and Waveney for putting all of its community services out to tender. At a Reform fringe meeting, shadow health minister Stephen O'Brien explained that a revolution in patient information would give patient choice the kickstart it has needed.

Radical policy

These are the kinds of ideas that explain why some senior Conservatives think people have not realised how radical their policy is. The three policy documents released under Mr Cameron underpin this vision of information, competition and choice. Top down targets would go, replaced by outcome measures, such as cancer survival rates. Commissioning would be separated from provision. A reformed tariff would target resources on providers that achieved better quality. And once the management of the NHS was decentralised and competition working, the Department of Health could take on a new role – "a Department of Public Health", as Mr Lansley said, speaking to Reform in 2008.

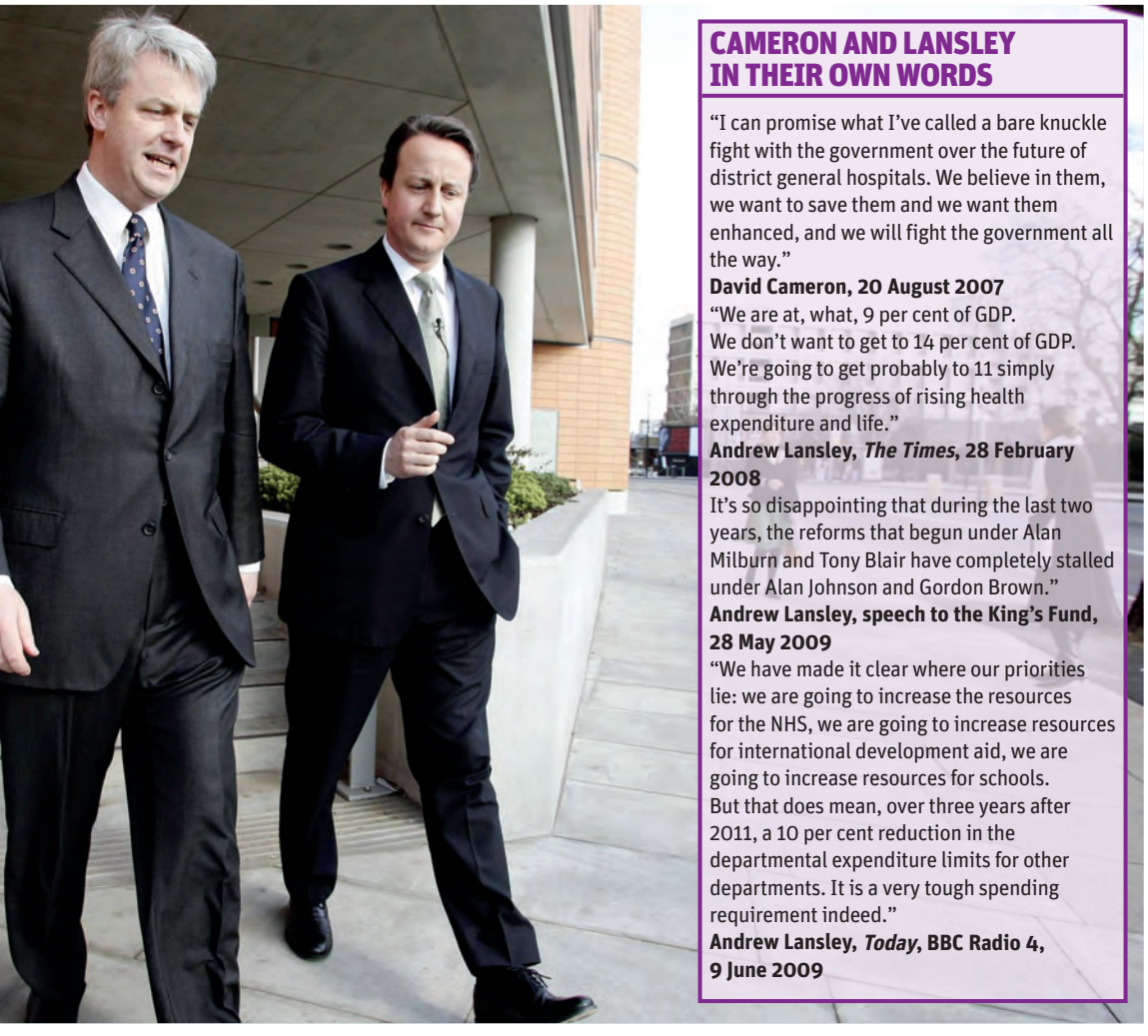
But this is not the whole story. There is another side to the Conservative policy which undermines what has gone before. Perhaps it was this contradiction that led former Conservative health secretary Stephen Dorrell to call for his party's spokesmen to shine "a little sunlight" on their policy before the general election (news, page 8, 15 October).

The problem is they have spent as much energy opposing change in the NHS as they have advocating it, in particular in 2007 when Mr Cameron opted to play the reactionary to then health minister Lord Darzi's reformer over district general hospitals.

A basic fact of the health debate is that modernisation, involving the development of primary care, integrated care and prevention, needs resources currently tied up in secondary care. District general hospitals, too small to offer comprehensive specialised care, are most in question. Yet Mr Cameron promised the government a "bare knuckle fight" over these hospitals, saying "we believe in them" and "we want to save them".

The Conservatives went on that autumn to campaign against "Gordon Brown's NHS cuts", defining a "cut" as any reduction in any service at all. They are still committed to a moratorium on hospital closures should they win office. These policies are bad enough in themselves but the collateral damage is the signal they send to the rest of the NHS – that change will only happen within strict limits, and that when push comes to shove, the historic pattern of provision, however inefficient, will be defended.

That signal has been reinforced by the commitment to spend more on the NHS no matter what in the next Parliament. As Reform consultant director Nick Bosanquet has said, nothing concentrates the minds of managers more than a declining



CAMERON AND LANSLEY IN THEIR OWN WORDS

"I can promise what I've called a bare knuckle fight with the government over the future of district general hospitals. We believe in them, we want to save them and we want them enhanced, and we will fight the government all the way."
David Cameron, 20 August 2007
"We are at, what, 9 per cent of GDP. We don't want to get to 14 per cent of GDP. We're going to get probably to 11 simply through the progress of rising health expenditure and life."
Andrew Lansley, *The Times*, 28 February 2008
It's so disappointing that during the last two years, the reforms that begun under Alan Milburn and Tony Blair have completely stalled under Alan Johnson and Gordon Brown."
Andrew Lansley, speech to the King's Fund, 28 May 2009
"We have made it clear where our priorities lie: we are going to increase the resources for the NHS, we are going to increase resources for international development aid, we are going to increase resources for schools. But that does mean, over three years after 2011, a 10 per cent reduction in the departmental expenditure limits for other departments. It is a very tough spending requirement indeed."
Andrew Lansley, *Today*, BBC Radio 4, 9 June 2009

budget. The Conservatives would not apply that pressure.

I happened to speak at the NHS Confederation annual conference in June on the day Andrew Lansley said on the *Today* programme that, because his budget would be protected, all his colleagues' departmental budgets would be cut by 10 per cent over three years. One primary care trust chief executive told me of her anger. She had been telling her senior staff the world was different now and the tough decisions on service redesign could be postponed no longer. Suddenly Andrew Lansley had taken the legs out from under her.

Another policy for the status quo is the commitment to give more commissioning power to GPs at the expense of PCTs: clearly GPs should be able to commission services on behalf of their patients. But GPs, even in collective form, will never be able to drive a redesign of services in a way that would challenge the big acute trusts.

'If NHS values are to be sustained the public should expect the day to day feel of the service to change in almost every respect'

So the party's appetite for reform is not as strong as it would have us believe. The incoherence in its position mirrors that of the government's throughout this Parliament; a government which nominally stands for competition and choice but which in practice has sought to soothe the professions rather than push for change.

But the government has been able to postpone the consequences of its prevarication with a tidal wave of money. The next government, inheriting a public sector that spends six pounds for every five it raises in tax, will not have that luxury. Protecting the producer, as the Conservatives promise, would leave the consumer to take the hit, unveiling the depressing prospect of rising waiting times and declining quality.

Given the need to revolutionise the pace of change, what should the Conservative policy vision be? Like Chris Ham, Birmingham University professor of health policy and management, Reform points to competing, vertically integrated insurers – almost certainly based on PCTs in the first instance – who can deliver integrated care and who have real incentives to improve population health.

Just as importantly, what should be their message? That if the values of the NHS are to be sustained, the public should expect the day to day feel of the NHS – its staffing and its buildings – to change in almost every respect.

That would be a tremendous change from their current position. But it would be consistent with David Cameron's pledges in his first days as party leader and with Andrew Lansley's decision not to follow Andy Burnham's grandstanding.

It would enable them to make progress towards the defining objective for the next government of whatever stripe – through reform, to reduce the fiscal deficit while achieving better social outcomes. ●

Andrew Haldenby is the director of the independent think tank Reform.

PA

OPINION

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SIMON STEVENS
ON BEING BEST IN THE WORLD

Torture the statistics until they confess. That seems to be the approach of many academics, journalists and policy wonks to the ideologically loaded question: which country's healthcare system is best?

The rot started with the infamous World Health Organization rankings of 2000, which put France first and the UK 18th. But then again San Marino (population 30,000) was placed third, and I doubt it even has a major hospital.

We have recently been treated to the latest such European effort, under the auspices of the Swedish presidency of the EU. The so called "Euro health consumer index" tries to rank the patient friendliness of national healthcare systems.

Tendentious? That would be putting it kindly. Entertaining? You bet. Here are just a few of their analytical *bon mots*: Germany's healthcare productivity may be due to the fact that "it is well known that hindering a German from working is difficult". The Dutch now have the highest per capita spending in Europe – except that they don't because that award goes to "the three rich bastards" of Norway, Switzerland and Luxembourg.

Albania is included "at the request of the Albanian ministry of health, who in a very nice email wrote 'we might well finish last but we want to be in there anyway'". Fear not: Albania swept the floor with Romania, Latvia and Bulgaria. And Albania's waiting times supposedly beat the NHS because "Albanians are a hardy lot, who only go to the doctor when carried there".

Of course it used not to be like this. "Fog in the Channel, Continent cut off" was roughly the approach. And this convenient solipsism meant that for much of the post war period we in Britain were able to console ourselves that the NHS was "efficient" simply because it was "cheap"; that being "tax-funded" automatically meant it was "equitable"; and "universal" necessarily equated with "patient responsiveness".

But now in an era of much greater transparency we are routinely challenged on that sort of complacency.

The problem is cross-national comparisons tend to have one of two ideological purposes: either to demonstrate that your own system is the best in the world, or to demonstrate the opposite – that the whole thing needs to be ditched and replaced. In other words, a battle between the self-deluding and the self-despising.

Those polar opposites have been on full display in the US health reform debate. So we have heard that the proposed reforms are part of a plot to introduce a "Nazi-style NHS". Alternatively we have heard that US healthcare needs to be blown up and completely replaced.

Fortunately, US public opinion is more nuanced than the ideologues would suggest. When the respected Pew Center surveyed Americans earlier this year, just over a third said the US healthcare system was the best or above average, about a third said average, and just under a third said below average.

In any event, each country's healthcare system is in important ways unique and highly local: a product of its distinctive history, its particular politics, its economic system, its geographical and cultural diversity, and its values.

So in health reform, you start from where you are, and you remember where you come from. For the US that means recognising that 85 per cent of the population has healthcare insurance and most say they are happy with it. It means recognising that (like half the G7 nations) many Americans – 160 million people – get coverage via their employer. And it means recognising that in a country as vast and diverse as the US, any attempt to impose a one size fits all straitjacket is unlikely to work. No other Western nation faces the challenge of organising healthcare for 300 million people. Try designing a single new healthcare system for Spain, Germany, Britain, France, Poland and the Netherlands and you get a sense of the challenge.

> **Comparisons of nations' healthcare tend to be self-deluding or to be self-despising**

But compared with other countries, two facts about how the US organises healthcare stand out. First, the US is alone among the major industrialised countries in not requiring its citizens to have healthcare coverage. And second, the costs are higher. So a key test of President Obama's proposed reforms will be whether he succeeds in tackling both items.

On the coverage question, Barack Obama fought the primary election against Hillary Clinton claiming she was wrong to argue that every American should be required to have healthcare coverage. In his recent joint address to Congress he (rightly in my view) changed his mind. That makes sense because in a purely voluntary system, people tend to defer signing up for health coverage until they need care, so that costs then go up for everyone, and some are forced to go without. (It is a bit like trying to take out fire insurance on your house when you see flames flickering in the basement.)

But enforcing a so called "individual mandate" requires action either to make healthcare more affordable for low and middle income families, or to add expensive and controversial new taxpayer funded subsidies.

On this issue, international comparisons of "the US versus the rest" are clear. American reformers should get more serious about cost containment, while taking the bull by the horns and mandating universal coverage. ●

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Seconds out for poll booth clash

The pre-election sparring has begun and the NHS will not escape some cuts. How tough things get will be a true test of how well money has been spent recently

We are now deep into the phoney war. The party conferences have been and gone; the pre-Budget report looms in November and then, eventually, the election.

The conferences in mellow early autumn days usually seem more glitter than substance to the outsider. My (limited) experience of party conferences was summed up one year when I found myself with a ticket for the floor of the conference hall for the big Tony Blair speech. The sense of theatre was all there, in the build-up, the carefully staged entrance and the departure. We left the hall to that well known socialist tune *Come Up and See Me* by Steve Harley and Cockney Rebel, which was perhaps meant to inspire thoughts of some gritty East End revolutionary, making common cause with Citizen Smith from Tooting. Anyway, at least we went out singing and foot tapping in a cheery mood.

This year's conferences have been different – a bit more policy, no joy and strong messages about pain to come. Labour offered a £0.7bn spending commitment on free parking (how will this work with private finance initiative deals, even if it was cheered by my wife's neighbour at a blood donating session?) and free care at home for the most needy. The Conservatives' big financial message, apart from continued investment, was a cut in bureaucracy at all levels to release £1.5bn.

But this is shadow boxing. The real event will be the pre-Budget report in the darker days of November. It is here that the government has its main opportunity to set out what it will do on tax and spending and draw some sharply defined battle lines. The strategy looks clear. A set of Labour spending and tax plans to flush out whether the Opposition will impose deeper cuts or (which seems less likely) higher taxes.

It must be a difficult balancing act – providing a credible set of figures for the international finance community on how the deficit will be managed down, not frightening the middle classes with tax increases and at the same time demonstrating how public services can be protected and even improved with the kind of additional commitments made at the party conference despite overall reductions in spending.

Health secretary Andy Burnham's proposal in his King's Fund speech early in September to issue a four year tariff is part of that plan. It will show the level of efficiency expected by providers, although it would be as well to remember that the tariff does not translate directly into income. PCT allocations are still the key. In 2008-09 the tariff uplift was 2.3 per cent but acute and specialist trust income rose by 6.8 per cent – just a little more than PCTs had to spend overall.

Up for it

But it surprises me how ready managers are for what lies ahead. Perhaps triggered by articles about armageddon and the tone that savings can be made (haven't McKinsey already done all the hard work?) we are now conditioned and fully expect to deliver. Managers I speak to seem to view the next three years with something approaching equanimity. It is the three after that they worry about. "We are up for it and up to it", as one Italian football manager with a masterful command of English put it when his team won.

'This is shadow boxing. The real event will be the pre-Budget report in November'

CHRIS EDE

It's a great can-do attitude. But there is a very long way to go to translate intellectual acceptance into action. I also wonder how ready we are for the personal sacrifices that may be involved – pay freezes and cuts, caps on pension payouts, lower pension benefits (probably) and significant redundancies and job losses for managers.

I also struggle with the notion that real savings can be delivered without reducing the number of frontline staff, unless everyone takes a real terms cut for several years or we have indeed created a fantastically bloated bureaucracy. It is worth remembering that even a one third cut in management costs will release an annual saving of less than 2 per cent, when 15-20 per cent is required.

Listening to one set of rhetoric, one might be forgiven for thinking that a cut in bureaucracy and the removal of targets and centralised management would result in a surge in productivity and quality. Rather like Labour in 1997, whose rhetoric suggested that removing the internal market and emphasising co-operation rather than competition would release many millions of pounds for patient care and set the NHS free for a great leap forward. If only.

It will require the sort of collective sustained effort that has transformed waiting times but with a bleaker underlying message and in a harsher environment, even with commitments to relative protection and extra investment. For if it proves to be easy it will be a real indictment of how the money has been spent in recent years. ●

Andy McKeon, is managing director of health at the Audit Commission.

FEEDBACK

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Breaking habits

Thank you for highlighting of the achievement of the smoke free homes service in Salford (leader, page 3, 8 October); having hundreds of children no longer living in smoke filled environments is a major contribution to health. This has been achieved through a partnership between NHS Salford as commissioner and the provider Unlimited Potential, a local social enterprise.

I would, however, take issue with the assertion that "Salford PCT has changed the habits of smokers". It is the people themselves who have changed their own habits, with some prompting and support. Without the contribution of citizens who are carers and self managers, or of groups and communities, then no army of professionals, however large, can make the change needed to improve health and reduce demand on health and social care.

What is true is your view that such achievements cannot be made without people with the skills to improve health. In our case, this means the people who form our smoke free homes team.

The "fully engaged scenario" we all need for improved health will only be achieved when we see beyond our own staffing levels and budgets to the often untapped resource that exists among local people themselves. How about positively planning to invest in these local assets, rather than the deficit based approach of funding ways to meet needs, often through importing resources?

Chris Dabbs, chief executive, Unlimited Potential

Supply and demand

How is the pharmaceutical industry tracking world class commissioning progress in England, specifically the commissioner/provider split and its implications? While there has been significant structural and operational change in the NHS in recent years, some strategic

ALAMY

'Having children no longer living in smoke filled environments is a major contribution to health'

recommendations, such as increased primary and secondary care commissioning of independent service providers and the move to deliver more services closer to the patient's home, have failed to materialise to the expected degree.

The question remains as to just how committed the government has been to using the private sector as an alternative source of supply. Has, in fact, the strategy been simply an opportunity to leverage the market and provide stimulus to mainstream NHS providers within the health service? Or, is it simply that the evolution towards greater adoption of private sector services has been constrained by the imbalance of power between commissioners and providers – particularly hospitals?

With the NHS now facing a massive budgetary challenge for 2011-14, it is reasonable to assume that many organisations will be taking a much closer look at the economics of private sector service delivery, especially if backed by a change in government to one far more commercially focused.

However, the emphasis must not just be on understanding the changing behaviour but on influencing that change to achieve objectives.

Understanding the NHS customer supply chain, identifying both customers and that customer's customer is key to not only identifying the chain of influence, but also to being more sophisticated about following those chains of influence to affect behaviour and prescribing practice.

Andy Etheridge, commercial director, Cegedim Dendrite

Listen closely

I would like to clarify our position on the Care Quality Commission's mental health inpatient survey (Feedback, page 16, 15 October). We have always supported the idea of a survey. What we questioned was elements of the way it was reported and communicated. The fact that 75 per cent of patients were satisfied by their treatment was, in our view, lost and needed to be highlighted.

Second, we have not criticised the idea of talking to mental health patients, nor listening to their views. Service user involvement is a central plank of the work of the New Vision coalition that the Mental Health Network chaired. Service user and carer consultants help direct the work of the network and we support the development of the acute pathway declaration which is based on the views of service users.

'This is Massachusetts, where locals can say "socialist" without foam appearing on their lips'
Tim Doran
www.hsj.co.uk/blogs

However, we did raise concerns about the size of the sample for some trusts. Also we know that acute units can be frightening and since the development of crisis teams the people admitted are often very ill.

There is absolutely no suggestion that because you are ill we think your views do not count.

Steve Shrubb, director, Mental Health Network

Whipps, cross

The Audit Commission's annual use of resources test suggests Whipps Cross University Hospital Trust is failing in a number of areas. It also says that this is for the fourth year running (news, page 9, 1 October).

The evaluation fails to recognise the significant improvements made over the last two years. The trust made a surplus in 2007-08 and 2008-09 and is forecasting a similar position this financial year. Moreover, all the auditors' local evaluation scores have improved with the exception of financial standing due solely to the historical debt. The latter is being used to bring down everything else.

This is demotivating to staff and the Audit Commission's assessment fails to convey any meaningful message. This is absurd. Under the current scoring system the trust could score 4 (the highest) in four of the five areas and earn a surplus and yet still fail. The evidence of real and tangible improved financial performance is ignored.

Time, perhaps, for a re-think to use a better system to rate NHS trusts?

Andy Morris, finance director, Whipps Cross University Hospital Trust

Ill people should still be heard

Who leads whom?

Sally Gainsbury's article on the commissioning and quality of GP services made some important points about the passivity of primary care commissioning (news analysis. page 12, 8 October).

One of the scandals of the current system is the way in which many GPs either disengage from delivering primary care to residents of care homes or charge exorbitant fees for a service that should be available to everyone in the community.

Two recent reports written by Maria Patterson at the English Community Care Association identified both the widespread nature of GPs demanding money to provide services and the ignorance of primary care trusts about this practice.

'GPs who have increasingly become a law unto themselves, doing less for more'

These reports highlighted either the unwillingness or inability of PCTs to manage their relationships with GPs who have increasingly become a law unto themselves, doing less for more.

It is time that all the money that has been put into world class commissioning processes by the Department of Health started to deliver some outcomes for patients.

Martin Green, chief executive, English Community Care Association

READERS' RESPONSES ONLINE

A selection of comments readers have posted online. To contribute go to www.hsj.co.uk/readerscomments or email hsj.feedback@emap.com

Top NHS managers urge against pay freeze
I really believe that if those without the experience were to go through a day in the life of an NHS operational manager, they would be stunned by the workload and the level of influence over delivering care to patients. Perhaps then they may feel differently about the "high" salary. There are opportunities to do less stressful jobs for more money outside of the NHS. The government should not encourage valuable NHS managers to walk away.

Health check improvements mask decline in acute trust performance
Get real NHS. Unacceptable. Totally unacceptable. A major step change in performance is required. Catch up with the safety management systems in other safety-critical sectors, set and deliver "zero harm" as the only acceptable way to work, begin to deliver all NHS care "right first time every time". Please believe you can do it, you owe it to all the patients, not just the proportion who get the absolutely excellent care we believe everyone is capable of.

GP commissioning shows little sign of life – David Colin-Thomé
Why should GPs participate? There is little financial incentive for them. With the new contract they are enjoying a much better lifestyle and being given more money to fund it. Why should they try and contain demand and take flak from difficult patients? Why should they try and improve access times? Why would they put their heads above the parapet to try and help deal with the NHS financial disaster mainly caused by government borrowing and profligacy over the years? They've cracked it, are happy, and everything else is secondary.

Mental health FTs allowed to treat private patients, but rules face fundamental review
The NHS should not subsidise private healthcare. Instead any private patient income from within a foundation trust should be priced and administered such that the NHS, and NHS patients, benefit from it. If such systems are put in place then theoretically there should be no ethical problem in any type of foundation trust undertaking private work. Unfortunately such a system does not appear to exist and the worry is that the private sector will exploit the situation to the detriment of the NHS. I am in favour of increasing the private work in FTs but a reasonable (and reasonably large) percentage of the private turnover should be used to support the NHS.

£1.5m spent on private care for NHS staff in three years
Firstly, the NHS has almost a million employees. While one might want to cover all their needs "in house", £1.50 per employee per year isn't a large spend on private healthcare; one suspects a lot more is being provided within the NHS. Secondly, I think we should have an explicit directive to the effect that NHS staff take priority. I'd suggest booting staff up a priority band (soons become urgents, routine cases become soons etc). This isn't just for the benefit of the staff but for the benefit of the organisation as a whole. View it as a perk if you will, but the NHS is one of the only employers to have the ability to truly prioritise staff health and we should take it.

Health check shows NHS is not focusing on quality – Andrew Lansley
Surely this is no surprise at all? Political imperatives from both sides of the house have forced providers to focus on cost and timeliness ahead of quality for a very long time now. More competition and more performance management is not the solution. Listening to the clinicians is. Not that any politician on earth will give much attention to that one.

RESOURCE CENTRE

PETE MASON ON HUMANS AND HAZARDS

The NHS and hazardous industries, such as aviation, often use the Swiss cheese model of accident causation, or the "cumulative act effect". The model likens human systems to several slices of Swiss cheese stacked together side by side. It was developed by James T Reason, a psychologist and author of *Managing the Risks of Organizational Accidents.*

Holes in the slices of cheese represent the imperfections in safeguards or defences. Reason says that most accidents can be traced to one or more of four levels of failure: equipment; processes; people and the hazard; or an unsafe act itself.

The system as a whole fails when holes in each of the slices align. Reason says this permits "a trajectory of accident opportunity", so that a hazard passes through a hole in each of the defences, leading to a system failure.

People should be encouraged to be responsible for their own actions, but failures should be seen as an opportunity for the collective to learn from mistakes.

Adverse events should, on the whole, be seen as a systemic failure, not as the fault of an individual.

This works best, however, in a blame-free error reporting culture – something that the hazardous industries have achieved more effectively than the NHS.

Whistleblowing has its place, but the NHS should move on from the stage where this is the default setting. Finding someone to blame will not help your team understand why something went wrong.

If the culture changes to one of accountability, the NHS can better manage patient risk. It is not effective to look for single acts or errors – adverse events usually occur because of a combination of different factors that have been part of the system for years without being changed.

Human beings make mistakes – errors will happen in the best run health systems in the best organisations.

Instead of attempting to sweep failure or imperfections under the carpet – as one NHS trust has recently been accused of doing when a nurse expressed concern over a colleague's qualifications – managers should address them.

Errors will happen in the best-run health systems and organisations

The nurse was allegedly relieved of her management responsibilities and told to drop the case. But if the employee whose credentials were in question had managed to slip through the layers of control and find employment in a position that really necessitated more appropriate training or qualifications, why not openly and honestly find a way to stop that situation occurring in future?

This might mean more stringent checks on potential employees, or better training offered to current staff to keep them up to date.

Medical error can be the result of system flaws, not just character flaws. There will always be holes in the NHS's layers of Swiss cheese.

But it can work to improve its systems, making those holes smaller and preventing them from aligning so often.

Pete Mason is a consultant a Lloydmasters.

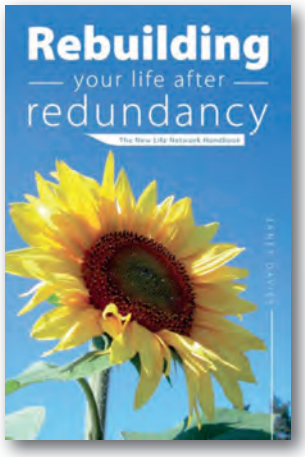
ONE MINUTE REVIEW

Losing a job is a new lease of life

The end can be a beginning if you are made redundant, says Julia Tybura

Rebuilding Your Life after Redundancy

★★★★☆



***Rebuilding Your Life after Redundancy*, Janet Davis, Arima 2009**

This book is described as "the essential one-stop shop for anyone needing to create a new and more enjoyable life after experiencing the trauma of redundancy". Davis's style is open, thoughtful and fun right from page one.

She starts with defining redundancy and then immediately goes on to how to manage your finances and your time effectively. For many people these two areas are central. Without sorting these basics out, they cannot move on to position themselves in the "marketplace" – whatever that may be.

In chapter five, she asks "what do you really, really want?" and recommends that you must not worry about the how before figuring out the why as you will just talk yourself out of your "brilliant idea" too soon. Good advice indeed as it makes the reader step back and think, rather than getting into action mode immediately.

This book is full of pragmatic, commonsense tips. Obvious ones like "to network well you need to have faith in yourself" are helpful reminders. Davis also offers several chapters on alternative careers.

The book ends with a rich list of references, networks, websites and further reading.

Davis has definitely done her research, which provides a good springboard for those in need of help and information at a difficult time in their careers.

As an experienced HR professional I would recommend this book not just for those looking to structure their career following redundancy but as a practical and motivational toolkit to focus the mind on current career options and future work-life aspirations. ●

Julia Tybura is managing director of Zenon Consulting.

JOIN OUR MANAGEMENT REVIEWS

Are you up to speed with the latest management thinking? If you would like to review management journals or books for *HSJ*, email your suggestions to hsjresourcecentre@emap.com

FINANCE

What all foundation trusts

Foundation trusts should watch how the top companies fight their corner on the stock exchange, says Mike Hay

Achieving foundation trust status ensures a high profile that both acknowledges excellence and invites scrutiny. It creates more space to innovate, and opportunity for the organisation to take control of its destiny. But with ambition comes risk.

The history of other, familiar leagues of top organisations provides some sobering reflection. Take the FTSE 100: this lists the hundred biggest public companies in the UK. Tenure on the FTSE 100 can be short lived: size and status are no guarantees of sustained success. What lessons does the rise and fall of companies on the FTSE hold for foundation trusts?

Of the 100 biggest companies in the year 2000, many are no longer even in the top 350 today. Some of these have disappeared through name changes, moving abroad or mergers, but our analysis showed 12 businesses that had clearly failed – declared bankruptcy, shrivelled to a husk of their former strength or been taken over by a competitor. There are some common themes behind their demise:

'When Tesco found itself falling behind it went and talked to 250,000 customers'

Overexpansion Many companies fuelled their expansion with debt. While the going is good there seems little downside, but the going is never good for ever.

Experimentation When you are good at what you do, it is tempting to think you will be good at anything you do, failing to recognise when success is built on specific strengths.

Failure to change Communities and customers are constantly evolving. The converse of overdiversification is the failure to change at all.

Poisonous acquisitions Merger and acquisition is the "national sport" of the FTSE 100. It is glamorous and exciting. It is also frequently deadly.

Brutal cost cutting When things start to look shaky, companies sustain profits by taking costs out of the business. Too often, cost cutting ends up weakening the organisation.

Failed collaboration Big joint ventures divert management attention and are tricky to back away from.

Many of these themes are equally applicable to foundation trusts. They have the power to manage borrowing to invest; many are exploring innovative service offerings with other partners; and all are charged with responding to local health needs.

In the current economic climate, value for money is at the top of the agenda.

Lessons for trusts

What lessons can be learned from this experience to help foundation trusts avoid the perils of success?

Understand what you are good at

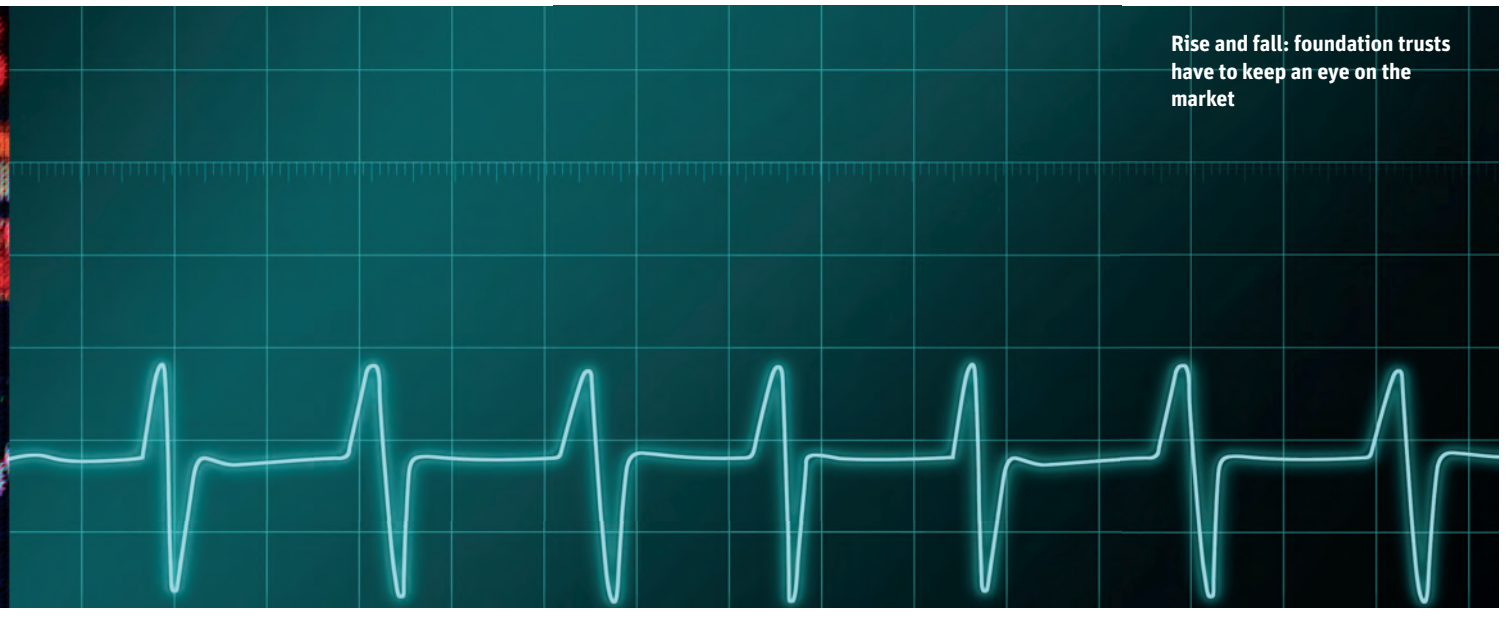
- Agree as a senior team what your core organisational strengths and competencies are
- Evaluate any expansion, merger or innovation in terms of these core strengths

Be sceptical of takeovers

- Be clear on the benefit to your organisation and stakeholders from the takeover, and walk away if there is none
- Understand the true causes of failure in the other organisation – can you genuinely improve them?
- Conduct due diligence on the intangible assets – culture, talent, leadership, relationships

PUBLICISE YOUR ORGANISATION'S IDEAS

In the next few weeks we will be publishing articles on decommissioning services and on collecting effective data and smoking. If you would like to highlight your organisation's ideas and examples of best practice both in *HSJ* and at the online Resource Centre, email hsjresourcecentre@emap.com

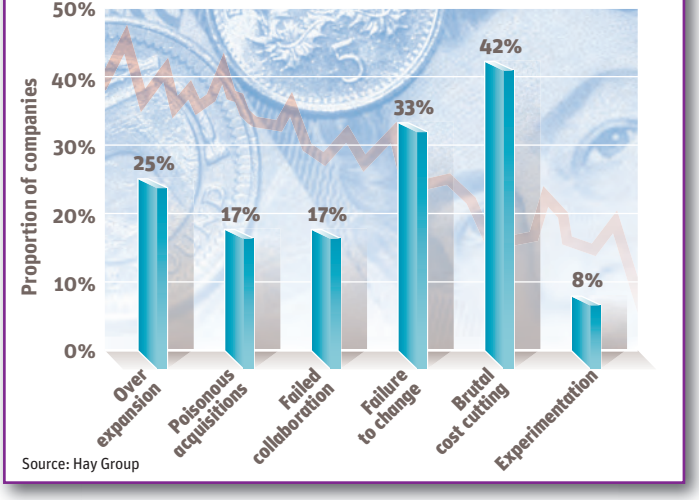


Rise and fall: foundation trusts have to keep an eye on the market

can learn from the FTSE

THE PERILS OF SUCCESS

Common themes in the demise of FTSE companies



Source: Hay Group

Demoralisation undermines efficiency

- Make the case for efficiency in terms of benefits to patients, free up staff time to do the things they are good at
- Rather than just cuts, you may need to radically rethink service provision. What does your community really notice and value? Which organisations are best placed to deliver it?

Keep in touch

- As well as formal consultations, ensure your senior leadership team directly shares in the patients' experience regularly
- When you spot change coming, respond with small, incremental initiatives which test the right approach and learn the lessons they offer

Delivery is as important as vision

- Invest in performance management for all your staff as a sustained, relevant experience, rather than a disconnected annual event
- Ensure individual accountabilities embed the strategy in the day to day decisions of all employees

Perfect blend

Failure is not the inevitable fate of all large organisations; there are companies that have sustained a top position in the FTSE for decades or more.

If they have anything in common, it is an intriguing blend of confidence and humility. They know what they are good at but they never believe they are perfect or have all the answers – they stay intently focused on the world around them, watching for the seeds of change or dissatisfaction.

When Tesco found itself falling behind competitors in the 1990s it spoke to 250,000 customers. In the words of Sir Terry Leahy, its chief executive: "What came out of this was a shock. Customers told us we were not giving them value. From that day on we determined to follow the customer and not the competition."

Sir Terry still spends a week every year working on the tills and packing shelves.

Similarly, Unilever knows that its strength comes from quality management. It continues to invest in this "basic", whatever the pressures to reduce costs.

Self awareness and customer focus: these are assets within the grasp of every organisation, and certainly a recipe for foundation trusts sustaining their well earned success into the long term. ●

Mike Hay is head of healthcare consulting at Hay Group, www.haygroup.co.uk

PA, FOTOLIA, AL GRANT

LOWER LEG CARE

No one left out on a limb

Leg Clubs are a social model for managing treatment such as ulcer care, where patients can feel in control and share information, says Julian Tyndale-Biscoe

Leg ulcers affect 55,000-90,000 people, mostly aged over 65, in the UK at any one time. Traditional care pathways see patients treated in their homes by district nurses, or in GP clinics. However, evidence shows this is costly with slow healing rates and a high incidence of recurrence.

One approach – now being referenced by the Department of Health in its QIPP (quality, innovation, productivity and prevention) programme – is the Leg Club model. This has been shown to improve healing, reduce recurrence and offer a cost effective framework for the treatment of lower leg problems.

It is a social model of lower leg care developed by former Nurse of the Year Ellie Lindsay.

"Collaborative working is the bedrock of each Leg Club," says Ms Lindsay.

"Patients and nurses work together in an open environment (patients can be treated in private if they wish), where interactive learning is paramount. Treatment is undertaken in an area where two or three people can have their legs washed and dressed in the same room, giving them the opportunity to compare healing and treatments."

Patients are encouraged to discuss treatment openly with the care team, carers and other patients, and this offers them control over their own leg problems. Clubs are run once or twice a week depending on local need and resources, with up to 40 patients attending each session. Leg Clubs currently operate in 20 locations across England, Wales and Scotland.

Input from GPs is kept to a minimum. Requests are made for antibiotics when needed and for appropriate onward referral to vascular surgery when Doppler assessments reveal arterial problems.

Community partners

Established and run by volunteers in partnership with nurses, they are self-funding, with patients and the community finding various ways of raising money for the rent and equipment. The cost to the commissioner is in nursing time and dressings.

Clubs are supported by The Lindsay Leg Club Foundation, which provides guidance and training during the setting up phase. Health and safety and infection control are primary considerations, clearly covered by documented guidelines and risk assessment.

The foundation provides a handbook to ensure all staff in Leg Clubs have a reference book that is simple and instructive.

During the embryonic stage of each club, nursing teams are encouraged to meet and liaise with their tissue viability nurse, lymphoedema nurse, consultant vascular surgeon/nurse specialist, infection control nurse and the director of provider services.

"The ethos of the Lindsay Leg Club Model is to encourage wellness rather than treat illness

40

Number of patients with lower leg problems who might attend a club session at one time, enabling them to share experiences

20

Locations where Leg Clubs are operating across the UK

CASE STUDY: CHANGING LIVES IN WORCESTER

For patients like 79 year old Vera Barrett, Leg Clubs help them turn their lives around. She says she rarely went beyond her front door and was effectively housebound. Her contact with the outside world included the twice daily visits from her district nurse.

"Sometimes my legs were so bad I couldn't get to bed," she says.

Now she and around 30 others with lower leg problems can visit one of two Leg Clubs in Worcester. They meet in a social environment where they can chat and have their legs treated by one of a team of community district nurses.

QUALITY CARE FOR ALL

The Department of Health references the benefits of the Leg Club model, which include:

- reduced costs as a result of fewer home visits
- care delivered in non-medical setting without the need for appointments
- patients encouraged and supported by peers
- care co-ordinated with other services

SUPPORTING SELF CARE

Gain insight on how to make self care and personalised care planning work at *HSJ*'s conference in London on 12 November
www.hsj-selfcare.com

MORE BEST PRACTICE ONLINE

Resource Centre is online too. Log on to hsj.co.uk for practical advice from readers, and tell us about your own work as well
www.hsj.co.uk/resource-centre

'Nurses and patients work together in an open environment which gives patients control'

LEG CLUB PRINCIPLES

Non-medical setting (eg, community/church/village hall) This avoids the stigma or fear of attending a medical setting and reinforces the community ownership of the club.
Informal, open access, no appointment required This encourages opportunistic attendance for information and advice, providing greatly increased opportunities for early diagnosis and leg ulcer prevention and helps isolated older people reintegrate into their community.
Collective treatment People share their experience, gaining peer support, and encouraging them to take ownership of their treatment.
Integrated "well leg" regime. This supports maintenance of healthy legs, positive health beliefs and broad health promotion.

in all age groups. It is a proven alternative to the traditional management of leg conditions. The fact that Leg Clubs encourage people to be fully involved in their treatment provides real motivation to individuals who are living with chronic wounds," says Ellie Lindsay. ●

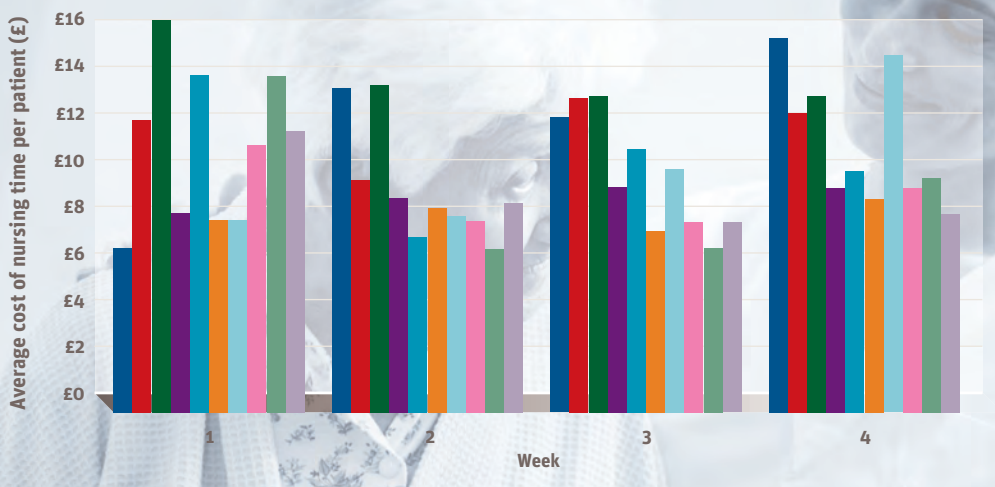
Julian Tyndale-Biscoe is managing director of InHealth Communications and trustee of the Lindsay Leg Club Foundation.

FIND OUT MORE

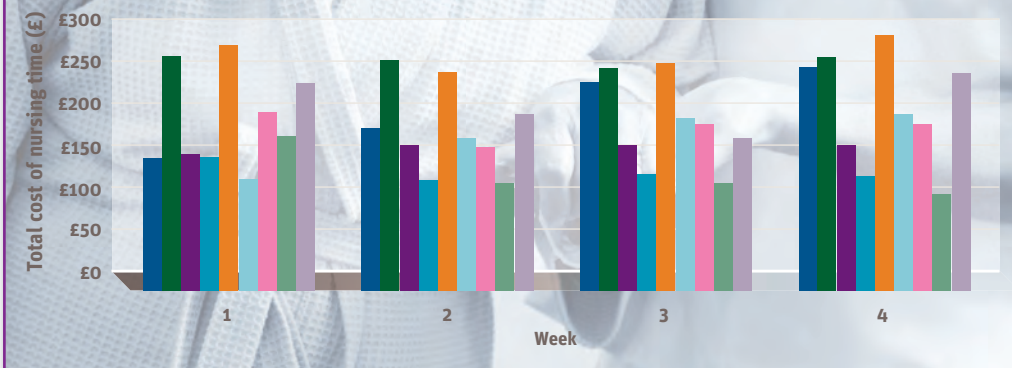
➔**www.legclub.org**

LEG CLUBS' COMMUNITY SETTING HELPS CONTAIN COSTS

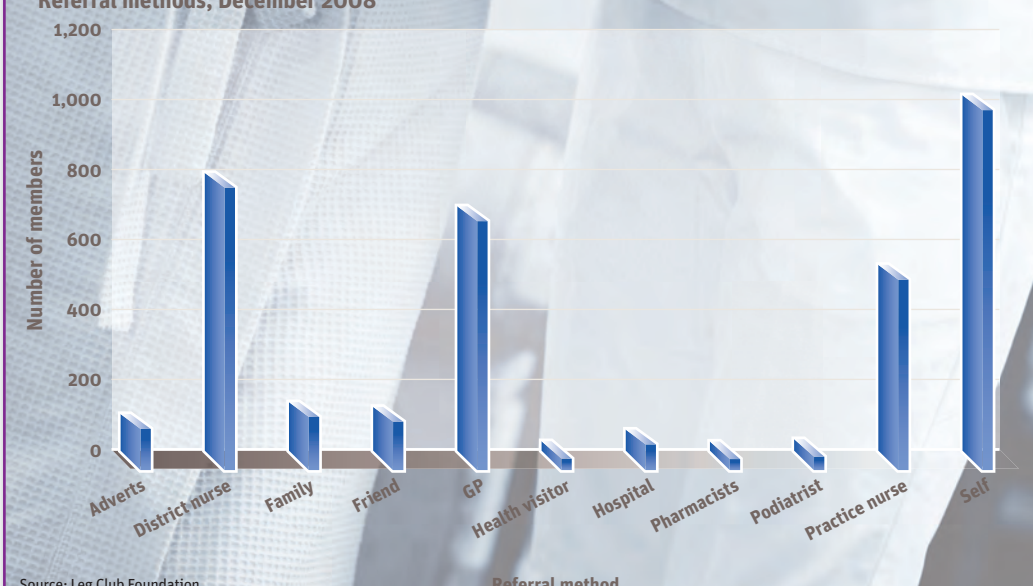
Average cost per patient per week of nursing time at 10 Leg Clubs



Total cost of nursing time per Leg Club per week at nine clubs



Referral methods, December 2008



Source: Leg Club Foundation

AL GRANT

LEGAL

How to get finance that adds up

Public-private partnership arrangements can be the right alternative to PFI for some trusts' equipment upgrades, say Stephen Lansdown and Shelley Thomas

The need to balance finances, manage risk and drive efficiencies are common themes in today's NHS. Delivering high quality, safe patient care while achieving the 18 week target is a constant demand.

Technology in radiography, diagnostic imaging and nuclear medicine is developing fast. Indeed, the NHS's electronic system PACS demands hospitals have up to date equipment, training, and support and maintenance services to achieve the Department of Health's objective of joined up, modern healthcare provision.

But such equipment is often costly, expensive to maintain and quickly superseded by newer technology.

A trust considering an equipment upgrade might implement a managed replacement project. Nothing new there. New medical equipment has been procured through larger private finance initiative schemes for some time. Trusts which have engaged specialist contractors for this have been able to call on private sector expertise.

Expected constraints on capital expenditure budgets beyond 2012-13 will reduce the amount of PFI. And for some trusts that is not in any event the right solution.

A standalone managed equipment replacement project based on a public-private partnership allows a trust to manage the cost and spread it across the life of a contract with an external provider (typically 15-20 years). The project is "standalone" in the sense that it is procured without a larger private finance scheme.

Radiology and diagnostic imaging are where the equipment is most suitable for this type of project, but the principles can be applied elsewhere in the trust's operations, such as anaesthetics, patient monitoring, ophthalmics and endoscopy.

In essence, the contractor takes on responsibility on an outsourced basis for supplying, maintaining, repairing and ensuring the operation of the equipment, for a regular payment from the trust. Typically the contractor will fund the equipment replacement programme using asset finance.

All-inclusive

The public-private arrangements typically involve the contractor, as well as bearing the capital cost of the required upgrade, providing services such as maintenance, support and training to the trust.

Diagnostic equipment is most suitable for public-private partnerships

SCIENCE PHOTO LIBRARY

CASE STUDY

Southport and Ormskirk Hospital trust entered into a 20 year managed equipment replacement project in 2007.

The contract involves the diagnostic imaging equipment at the trust's two main hospitals being replaced and refreshed with the latest technology, following a pre-agreed phased programme. Service and training are included, and significant technology, financial and other risks are transferred from the trust to the contractor. New equipment in the initial phase includes: digital, general and mobile X-ray; fluoroscopy; digital mammography; ultrasound and mobile C-arms. At the end of the lifecycle of the current equipment, the trust's CT scanners, MRI scanner and direct digital chest X-ray will also have been replaced.

This contractor financed programme is allowing the trust to reorganise services and improve the patient experience.
➔www.southportandormskirk.nhs.uk

Some new or replacement equipment is usually installed at the start of the project and then, working around the life cycle of the current equipment, other equipment is replaced on a pre-agreed rolling basis.

Benefits include:

- delivering cost savings;
- removing unpredictability in long term capital expenditure;
- offering certainty as to equipment uptime and service quality (most payment mechanisms in these projects are based on equipment availability times and monthly performance measurements);
- providing new and up to date equipment at regular, pre-agreed intervals;
- reducing capital charges (if off balance sheet treatment can be secured).

Despite the introduction of international financial reporting standards, carefully structured managed equipment replacement projects which transfer significant technology, financial and other risks to the contractor may still be off the NHS balance sheet. Some examples of major risks that the trust should expect a contractor to bear include:

- supply, maintenance and repair of the equipment
- equipment downtime
- technology updates
- equipment obsolescence
- changes in maintenance and support charges, interest rates and other costs
- removal of the equipment on expiry or earlier termination. ●

Stephen Lansdown is head of commerce and technology and Shelley Thomas is an associate at Hill Dickinson, www.hilldickinson.com

HUMAN RESOURCES

Why bullying has no benefits

Managers should never forget that good performance requires morale-boosting not ego-bashing, advises Paul Beal

The Department of Health investigation into NHS East Midlands highlights the issues of alleged bullying at the highest level in the NHS.

Strategic health authority performance meetings should be challenging and supportive to organisations; not "a kicking session" as many executives have called it, with behaviour at times verging on what could be perceived as bullying. That kind of behaviour can transfer to the whole organisation.

The outcome of the DH investigation should create an opportunity to develop a new approach to performance management, making senior managers more aware of the impact of their behaviours.

In recent years I have seen people return from NHS leadership programmes with what they believe are the skills to challenge. My observation has been that they have gained little insight into how their challenging behaviour affects their colleagues.

Staff on the front line are constantly under the pressure of budget constraints, targets and managing the care of patients. Given the current climate and the prospect for the future, the pressure is likely to increase, with productivity initiatives and savings programmes. If staff continue to be managed in a challenging way, many may perceive it as bullying and harassment.

Having worked in the NHS for many years as a director, I have been involved in dealing with alleged cases of bullying and harassment. In many cases this is about behaviours and attitudes of individuals which become part of the culture of the organisation.

Some organisations tolerate bad and negative behaviours and do not routinely tackle them at every level.

By addressing performance from the top down and communicating effectively with a supportive and developmental approach, an organisation can benefit from a healthy approach to management while achieving the tangible returns of increased productivity and a motivated workforce.

The change cycle does not happen overnight; it takes time and does require leadership by example. I recall an NHS organisation where I introduced a new performance management policy, with a training programme to support this. The approach was to get managers to manage the performance rather than use formal disciplinary procedures and to deal with issues through regular one to ones and feedback.

'Performance meetings should be challenging, but not kicking sessions'

Initially, there were some sceptics. Even the trade unions were wary of this approach. However, with the support of the HR team and working with managers and trade unions we started to change the culture. In time everyone understood "the deal" and was supportive of the cultural shift.

Developing an effective performance management culture in the organisation benefits both management and staff and this has a positive impact on patient care. The initiative needs to come from the board and the executive team, role modelling leadership behaviours and holding people to account.

Getting the basics right is crucial. This involves regular feedback and rewarding good performance, not tolerating poor performance or bad behaviours. Communicating an expectation of this throughout the organisation is fundamental.

The HR function has a central role in supporting this cultural shift through coaching, having strong policies, training and developing managers in good practice and supporting them when cases need to be dealt with through formal processes.

We owe this to our staff, patients and the public to get the best out of the workforce. We should not shy away from this at any level in the NHS, whether as a manager or a clinician. ●

Paul Beal is managing director of Consulting at 216.

In your face: lead by example not by aggression

ALAMY

10 TIPS TO DEVELOP AN EFFECTIVE PERFORMANCE CULTURE

- Build the relationship with staff
- Lead by example
- Be self aware about the impact of your behaviour
- Use regular two-way feedback
- Deal with issues as they arise
- Have regular 1:1 meetings
- Ensure appraisals have clear objectives and provide personal development plans
- Use your HR managers as a sounding board
- Have clear and robust HR policies understood by all
- Be clear about consequences of continued underperformance

Make us even better

NHS Lambeth

NHS Lambeth spend approximately £575 million each year on improving health and health services. Our mission is to improve health throughout the diverse communities we serve and ensure consistently high quality of services.

NHS Lambeth is the only PCT in England to have achieved results of good or excellent in both 'quality of services' and 'use of resources' every year since the Annual Health Check was introduced in 2005.

Critical to our ongoing success and becoming a world class commissioner, is the recruitment of a new Executive Director of Strategy and Services, Director of Care Groups and Director of Primary Care.

Having the right people in the right place to support organisational objectives is key to our ongoing success as we aim to become leaner and more 'commissioning focussed' and further develop our profile and position amongst the country's top performing NHS organisations.

Executive Director of Strategy and Services

Attractive salary plus benefits (VSM) **London**

Reporting to the Chief Executive, you will have responsibility for taking forward the Healthcare for London programme and strategic leadership and development of borough based commissioning, including the commissioning of mental health services, client group and community services with the Local Authority and GP and contractors services.

Building on the excellent relationships already developed the post holder will need to ensure systematic engagement in all aspects of commissioning. You will need to develop, with the PEC, opportunities for GPs (through PBC), other clinicians and our partners and local people to participate directly in commissioning for quality.

Director of Primary Care

Attractive salary plus benefits (Band 9) **London**

The Director of Primary Care will have overall responsibility for the commissioning and development of all Primary Care services across Lambeth supporting the Executive Director in the development of the overall commissioning strategy. Reporting the Executive Director of Strategy and Services, you will also be responsible for ensuring that relevant national and local targets are met and services are delivered.

Director of Care Groups

Attractive salary plus benefits (Band 9) **London**

The Director of Care Groups will have overall responsibility for developing the commissioning of services for all client groups and community services across NHS Lambeth taking account of national policy. Reporting to the Executive Director of Strategy and Services, you will also be responsible for ensuring that national and local targets are met within agreed budgets.

For more information on these exciting opportunities including details of how to apply please visit www.harveynash.com/nhslambeth

For a confidential discussion please call Frank McKenna, Director of NHS & Healthcare on +44 (0)20 7333 1516 or Chris Davies, Senior Consultant, NHS and Healthcare on +44 (0)20 7333 1538. To apply please email your CV and covering letter to: pippa.hogg@harveynash.com or write to Harvey Nash plc, 13 Bruton Street, London W1J 6QA. Closing date for applications is 9th November at 9am. Harvey Nash is a global executive search consultancy.
Complying with the BERR: We are an Employment Agency.

HARVEY NASH
The Power of Talent
www.harveynash.com

H41407B9

SALARY BAND 9 & HIGHER

hsjjobs.com

Director of Operations/ Deputy Chief Executive

Colchester Hospital University NHS
NHS Foundation Trust

Circa £125,000 + benefits **Colchester**

Colchester Hospital University NHS FT is a successful acute hospital trust that achieved FT status in 2008. With an operating turnover of over £180m and a workforce of 3,500, we provide acute medical and surgical care across two main sites to a population of almost 400,000 in North Essex, and specialist services to some 680,000 across north and mid–Essex. We are ambitious to further enhance the quality of care provided and to become a provider of choice to our local population and beyond.

We are now seeking a dynamic Director of Operations and Deputy Chief Executive who will oversee the operational leadership and performance management of the Trust's clinical services. You will need to have strategic vision and tenacity to take the lead in capacity planning, service transformation and the redesign of services that will see the Trust at the forefront of clinical service delivery and innovation.

You will have high visibility across and outside the organisation and will ensure that we are positioned to capitalise on our strategic ambitions as well as placing patient experience and safety at the heart of our operational delivery.

To succeed in this role you will need to be:
- Able to drive motivation and continual performance improvement within a highly professional clinical and managerial workforce
- Strong decision making and analytical skills, with a focus on delivering impressive results and innovative solutions
- An ability to contribute across all aspects of the Trust's activities, performance and development

Your credentials
- A highly able, collaborative and inspirational leader, able to command credibility at Board Level and to constructively challenge internal and external stakeholders
- Excellent strategic leadership skills and a demonstrable track record of operational delivery in a complex healthcare organisation
- Highly developed interpersonal and diplomatic skills for influencing change, managing complex situations and sustaining engagement and delivery

For further information, please visit our microsite at www.harveynash.com/colechesterdeputyceo

For a confidential discussion, please contact Frank McKenna, Director, NHS & Healthcare on +44 (0)20 7333 1538 or Chris Davies, Senior Consultant, NHS & Healthcare on +44 (0)20 7333 1516. Please email your CV and covering letter to: pippa.hogg@harveynash.com or write to Harvey Nash plc, 13 Bruton Street, London W1J 6QA quoting reference number HN5244HSJ. Closing date is 6th November 2009.
Harvey Nash is a global executive search consultancy.
Complying with the BERR: We are an Employment Agency.

HARVEY NASH
The Power of Talent
www.harveynash.com

H41408B9

Director of Public Health

Knowsley Council | NHS Knowsley

NHS Knowsley/Knowsley Council – joint appointment
Circa £100,000 plus relocation

In Knowsley, we are committed to ensuring that in everything we do we are ***improving people's lives***. One of the first places to have a jointly appointed Director of Public Health, the groundbreaking partnership between NHS Knowsley and Knowsley Council enables us to put the needs of our communities at the heart of everything we do. We have just won the Municipal Journal 'Reducing Health Inequalities Achievement' award for the third time in five years. The Award recognises our shared success in improving health and reducing health inequalities in the Borough over the last decade.

Our fantastic achievements have been made possible due to our unique partnership arrangements including the use of pooled budgets and a long-term relationship with our communities, which have provided the foundation to achieve real improvements for our population.

Despite the success we have enjoyed, we also recognise the challenges that we face to realise our vision that the people we serve will be more informed and involved in decisions that affect them, and will experience better health and wellbeing and improve health and wellbeing services.

Reporting to both Chief Executives, this post is a superb opportunity to work across two high-performing organisations and the wider community to ensure that our citizens are able to enjoy the excellent physical and mental health they deserve. Providing strategic and inspirational leadership, you will promote and protect health and wellbeing, tackling health inequalities, improving quality and working collaboratively to improve the health and wellbeing of the population. You will help to promote and develop a culture of continuous improvement, ensuring the widest possible participation in the health and wellbeing agenda to support the development and delivery of our ambitious strategic objectives. You will focus strongly on making the best use of resources to do so.

We're looking for an appropriately qualified and experienced public health professional, who is able to operate successfully across both the health service and local government, and within a range of partnership settings. A proven 'change agent', you will be able to really engage with the community and other stakeholders and will possess the skills to act as a health champion and consultant on public health issues across the two organisations. We want your help to move even further and faster!

Can you step up to the challenge? If the answer is yes, then visit **www.gatenbysanderson.com** to hear what some of our citizens think about us. For a confidential discussion, call our advising consultants at GatenbySanderson – **Nick Raper** on **0113 205 6076** or **Simon Potts** on **0113 205 6283.**

Closing date: 12th October 2009.

GatenbySanderson
www.gatenbysanderson.com

H41402B9

Working Together For Health and Wellbeing

NHS Chief Executive and Strategic Director of Adult Social Care and Housing
Salary: circa £135,000

Bath and North East Somerset has worked dynamically to form an integrated Health and Wellbeing Partnership. It brings together the PCT and the Council's Adult Social Care & Housing and Children's Services into a single Partnership.

You will have a key role in building on the successes that have already been achieved. With dual accountability and governance frameworks across the Partnership, you will apply your leadership and organisational skills to unite the development of commissioning strategies and operational plans across health, social care and housing. Your contribution will ensure the commissioning and delivery of high quality, responsive and best value services to local people.

You are likely to have a proven track record at Board level in a health or social care organisation. Your transformational leadership skills will inspire confidence and enable you to deliver results. You will also be a numerate, analytical, influential and persuasive leader who can bring about change.

For an informal discussion please call Andrew Brown or Robin Staveley on 0121 233 7700.

For more information and to apply, please visit www.resourcingmicrosites.com/banes

Closing date: 13th November 2009.

TRIBAL

www.tribalresourcing.com

Bath & North East Somerset Council

NHS Bath and North East Somerset

H41415B9

Where EVERYONE Matters

Sandwell and West Birmingham Hospitals NHS Trust

NHS

Director of Workforce

Based at City Hospital, Birmingham
Salary: £105k

Sandwell and West Birmingham Hospitals NHS Trust is one of the largest hospital trusts in England, serving a population of around 500,000 and employing over 7000 staff. The Trust is highly successful, continually improving the quality of care we provide and delivering excellent financial and performance results.

Our strategic agenda is one of the most ambitious around. Through the long term Right Care Right Here Programme we are, in conjunction with our health economy partners, transforming the way in which care is delivered. As part of that, we will be building a brand new acute hospital, due to open in 2015/16. This scale of achievement and change requires fully engaged staff, which is being facilitated through our ground-breaking and highly effective Listening into Action Programme.

Add to all this the need to plan for the coming strictures in NHS funding and the scale of the workforce challenges involved here will be obvious. That is why we are seeking a first class Director of Workforce, who will be a voting member of the Trust Board. To be right for this job, you will need to be able to:

- Translate workforce theory into practice that makes a real difference on the ground
- Manage highly complex change programmes
- Contribute fully to corporate thinking
- Function as a real team player.

If you think that you might be the right person for us, please go to www.jobs.nhs.uk where a full information pack is available.

Closing date: 12th November 2009.

The Trust is committed to equality of opportunity and is a no smoking organisation.

www.swbh.nhs.uk

H41603B9

Queen Victoria Hospital is one of the country's highest performing Foundation Trusts and is one of only four Trusts to achieve a double 'Excellent' in the CQC's annual rating for the last three years. The Trust is responsible for providing world class specialist reconstructive services to the 4.2 million people of Kent, Surrey and Sussex and local community services for the people of East Grinstead and surrounds. Building on its many successes so far, the organisation has clear ambitions for the future, including the phased redevelopment of the hospital site to provide an environment that is conducive to even higher levels of innovation and excellence in the delivery of patient care.

EXECUTIVE DIRECTOR OF FINANCE & COMMERCE

Circa £100,000 • Ref: 9794

This key post is for an Executive Director of the Trust Board and we are seeking a natural leader capable of providing strategic vision and professional leadership. Currently working at an equivalent level within a comparable organisation in either the private or public services sector, you will have an entrepreneurial and commercial outlook, in-depth technical expertise and excel in service delivery. You must be able to ensure that all key financial systems are operating effectively, drive continued performance improvement and work with key stakeholders in developing financial strategy. You will be experienced in the formulation and delivery of business plans and corporate targets.

FINANCIAL CONTROLLER

Salary 8C • Ref: 9795

Working closely with the Executive Director of Finance & Commerce, the Financial Controller will have overall responsibility for all the functions within the Departments of Finance, Procurements & Supplies. Deputising for the Executive Director when necessary, you will have an excellent understanding of management accounting and an in-depth knowledge of activity based costing techniques. Self motivated with excellent communication and presentation skills; you will have the ability to manage large and complex projects requiring cross-departmental collaboration.

If you think you have the drive and credibility to meet the demands of either of these challenging roles, then we would be delighted to hear from you.

Black and Minority Ethnic staff are under-represented in the Trust's senior team and we would very much welcome applicants from this group.

For further information on the roles and details of how to apply, please go to www.veredus.co.uk and quote the relevant reference number. For an informal discussion, please contact Melanie Shearer on 020 7932 4393 or Helene Usherwood on 020 7932 4304.

Closing date: Friday 20th November 2009.

VEREDUS

Queen Victoria Hospital NHS
NHS Foundation Trust

H41403B9

Bold & ambitious

NHS Norfolk

Chief Operating Officer – Commissioning

VSM Pay Scale – c£120,000 • Norwich

We may be located in a tranquil and beautiful area with a quality of life rated in the UK's top ten, but that doesn't mean we're a sleepy backwater. With a £1.2 billion budget and 400 staff, NHS Norfolk is one the largest organisations of its type in the NHS. We are a fast paced, vibrant organisation responsible for commissioning healthcare services for the local population of 750,000.

In this role you will be responsible for driving the delivery of our bold and ambitious strategic plan through the organisations from whom we commission services.

Reporting directly to the Chief Executive, this is a Board level role leading a dynamic, newly formed, team of Directors who have responsibility for procurement, contract management, informatics, performance and relationship management.

We are open as to where you have gained your experience; it could be from the NHS, the wider public sector or from the private sector - Regardless of where it has been developed you must be able to demonstrate a measurable track record of driving transformational change in delivery and implementation.

You will achieve the translation of our vision into action through your charisma, presence and focus on results which will inspire and influence others at all levels.

You will have extensive expertise, at Board level, of empowering high performing teams, when appropriate taking key roles in client relationship management and adding true commercial focus to partnership working.

For a comprehensive insight into NHS Norfolk and to see filmed profiles of current senior figures speaking about their experiences of our organisation and to apply, visit www.boldandambitious.co.uk

TRIBAL

www.tribalresourcing.com

H41409B9

Director Of Operations

Ipswich : £Competitive Package

The Ipswich Hospital NHS
NHS Trust

We are one of the largest general hospitals in East Anglia and we provide healthcare services to a catchment population of 340,000. This high profile c£200m+ income Trust is now firmly setting its sights on Foundation Trust status. As a Trust Executive you will play a vital role in ensuring this achievement and all future successes of Ipswich Hospital. We strive to make our staff feel valued as reflected in our successful inclusion in the HSJ Healthcare Top 100 Employers. Achieving excellence in everything we do is the focus of all our work within the Trust hence we have an excellent track record of low hospital mortality rates. We pride ourselves on the quality of our staff and facilities and are continually working to improve the services we provide. We are looking to appoint a talented leader with vision, strong drive, dedication and a proven ability to deliver. This is an outstanding career opportunity for those candidates with future ambitions to reach Chief Executive level.

The Role:

- Provide visible and effective leadership across the Trust to ensure the delivery of all patient services, meeting all performance standards
- Lead the development of the Trust's clinical services, encouraging a culture of innovation, quality and excellence amongst frontline staff
- As an Executive Director lead on operational input to the annual and strategic planning process and contribute fully to improvements in patient safety

The Person:

- A driven, inspirational leader and collaborative leader with an enviable track record of operational delivery, improvement and innovation in an acute healthcare environment
- Experience of leading the strategic development and implementation of large scale change programmes
- A motivational, innovative and resilient individual with highly developed interpersonal and communication skills with an ability to engage stakeholders at every level

Please see www.jobs.nhs.uk ref 178-284-09 for a candidate brief containing application details.

For an informal discussion please contact our retained recruitment consultant, Neil Fineberg – Executive Director, Fine Green Associates, www.finegreen.co.uk, on 0845 130 4006.

More information about Ipswich Hospital NHS Trust can be found at www.ipswichhospital.net. Closing date for application – 16th November 2009

FINEGREEN
ASSOCIATES

Our Passion, Your Care

H41501B9

Chief Executive

NHS
Bournemouth and Poole

Competitive Salary

Serving a population of 343,000 in the heart of some of the south coast's most picturesque rural and seaside settings, NHS Bournemouth and Poole strives to improve the health of its local communities by commissioning and developing high quality, patient focussed services as an innovative leader across the health and social care system. With an annual budget of circa £500 million, NHS Bournemouth and Poole is a dynamic and successful organisation that achieved a rating of 'Excellent' for the quality of its services and 'Good' for its use of resources in the 08/09 Annual Health Check. However, the coming months and years will place the organisation and its partners under significant pressures to reduce operating costs and improve efficiency whilst still driving up the quality and effectiveness of healthcare services provided to the people of Bournemouth, Poole and the surrounding area. The appointment of the Chief Executive comes at a crucial time in which decisions will be taken that determine the success and sustainability of local NHS services in years to come.

The Role:

- Inspire and lead the PCT to manage the local health system, commissioning services that will deliver the best health outcomes for local people.
- Ensure the PCT continues to develop strong relationships with key partners, including acute and mental health providers, local authorities and wider stakeholders.
- Raise performance at all levels, driving forward development strategies within tight financial constraints.

The Candidate:

- A highly credible strategic leader with an excellent track record at board level, ideally although not exclusively within the healthcare sector.
- Politically astute individual with proven experience of developing partnerships and delivering integrated strategies.
- Commercially minded and innovative, with experience of driving change and performance improvement across a range of services.

To find out more, please see www.odgers.com/30061 for a candidate brief containing application instructions, or contact us quoting the reference CAG/30061HSJ. Closing date for applications is Monday 9th November.

11 Hanover Square,
London W1S 1JJ
0845 1309005
www.odgersberndtson.co.uk

ODGERS BERNDTSON
Executive Search
51 offices in 24 countries

H41502B9

CHIEF EXECUTIVE OFFICER – BIRMINGHAM

VSM Competitive Salary

JOIN OUR TEAM

Badger provides GP out-of-hours services in the Greater Birmingham and South Staffordshire area of the West Midlands. The organisation comprises a group of linked companies with at its heart a GP co-operative of 250 GP members. **Badger** has grown steadily since its foundation in 1996 and now provides care for over two million people. The growth of the organisation means that we are now seeking an outstanding CEO to lead the organisation from the front.

Badger is innovative and energetic with a quick turnaround from ideas to implementation. We enjoy a reputation for growth, team work, integrity and quality patient service. We are seeking a CEO who shares our values, can safeguard the **Badger** brand and can drive forward the future development of services. This is a hands on role so along with strategic, financial and people-management responsibilities you will be expected to play an active role in existing contract liaison and new business development .

You will be a graduate with a track record in managing and developing a successful health related service. You must be determined with high levels of drive and organisation. Balancing this you must have the charm, empathy and friendliness to build lasting supportive relationships with colleagues and stakeholders.

We offer a substantial salary, performance related bonus, NHS pension and the opportunity to direct and develop the **Badger** group of companies. If you are interested in this unique opportunity please send your CV to lesley.harris@badger.nhs.uk **by the 13th of November 2009. Panel dates 30/11 and 1/12/2009.**

Want to know more?

Call Terry Peate on:

0121 214 8641

or download an information pack from

www.badgermedical.org.uk

badger

CARE YOU CAN TRUST

H41401B9

SALARY BAND 9 & HIGHER

hsjjobs.com

POSITIVE ABOUT DISABLED PEOPLE

MINDFUL EMPLOYER

AGE POSITIVE

SMOKEFREE GLOUCESTERSHIRE

excellence

Gloucestershire COUNTY COUNCIL

NHS Gloucestershire Care Services

Joint Director of Operations (Adult Care)

Salary Range: £75,000 - £95,000

Ref: 744-G9-316

NHS Gloucestershire and Gloucestershire County Council are both dynamic organisations working to respond to the fast-moving changes and expectations in the health and social care environment. By working together we are making significant improvements in the delivery of health and social care services for our population of approximately 597,000.

In this high profile joint appointment, you will provide strategic leadership and effective operational management to build on the current partnership arrangements, promoting further integration and innovation to improve health and social care provision. You will lead the commissioning of appropriate health and social care packages developing partnerships with independent and voluntary sector organisations. Importantly, you will ensure that service delivery complies with statutory requirements whilst being safe, effective and efficient.

To be successful in this role you will need:

- To be of exceptional senior management calibre coupled with extensive and current NHS and Social Care experience
- Masters level (or equivalent) in a relevant Health or Social Care qualification
- Substantial experience of service development and delivery in a multi agency environment
- Experience of working in a political environment and of presenting information to the public.

For informal enquiries please contact Margaret Sheather (Gloucestershire County Council) on 01452 425102 or Jan Stubbings (NHS Gloucestershire) on 08454 221683.

Closing date: 9th November 2009.

Assessment centre and interviews to be held: Week commencing 30th November 2009.

To find out more about the work of NHS Gloucestershire and Gloucestershire County Council, please visit www.glospct.nhs.uk and www.gloucestershire.gov.uk

For further information and to apply for this post please visit www.jobs.nhs.uk

H41419B9

SALARY BAND 9 & HIGHER

EAST SUSSEX HOSPITALS NHS TRUST *provides a comprehensive range of general acute hospital services from two main district general hospitals, the Conquest Hospital in Hastings and the District General Hospital in Eastbourne, which serves a population of approximately 500,000. With a budget in excess of £270 million, we employ around 5,000 staff and offer an excellent range of staff amenities.*

Financial Director

Full-time Ref: JA380CE

East Sussex Hospitals NHS Trust is looking for an outstanding Financial Director to support our strategy to become the provider of choice for healthcare services for our local population. You will be key in driving forward a programme of reform that will guarantee continued delivery of the high quality care already provided by the Trust, within an affordable framework.

You will be a voting board member and will need to have previous experience at this level, with an ability to command credibility and to constructively challenge internal and external partners. In addition, you will need to have a demonstrable track record of financial management and delivery in a large and complex organisation. Excellent strategic leadership, management and communication skills are vital. Commercial acumen and entrepreneurial skills to deliver a strong solutions focus will be a key part of the job.

The exceptional calibre of the successful candidate is recognised with a substantial remuneration package in excess of £120k.

You must hold a CCAB recognised qualification.

For further information or an informal discussion, please contact Kim Hodgson, Chief Executive, via her PA on 01323 413864 leaving your name and telephone contact details.

Apply online at www.esht.nhs.uk/recruitment

Closing date: 9th November 2009.
Interview date: 27th November 2009.

The Trust is committed to equality of opportunity. Job shares are considered for all positions.

East Sussex Hospitals NHS
NHS Trust
www.esht.nhs.uk

H41422B9

Homerton University Hospital NHS
NHS Foundation Trust

Visit our website www.homerton.nhs.uk/workforus

Chief Nurse and Director of Governance

Competitive Salary

Homerton University Hospital NHS Foundation Trust is a progressive and highly-regarded Trust based in the east London borough of Hackney. With an income of £170 million the Trust provides a full complement of general healthcare services to its local population and a range of specialist services for a wider population. In the annual health check, the Healthcare Commission rated the hospital 'Excellent' for both quality of services and use of resources. Situated just 3kms from the London 2012 Olympic and Paralympic Park, we are the designated Olympic hospital.

A formal review of the Trust's strategic options is underway to consider how it can best contribute to health care provision in London. This is an exciting opportunity to join us at a time of strategic development and change.

The Chief Nurse has Board level responsibility for the strategic and professional leadership of nurses and midwives. As Director of Governance you will lead the Trust's programme of integrated governance including risk management, clinical quality and safety, improving the patient experience and public engagement. You will be expected to ensure the trust operates within its required legal and mandatory frameworks.

A highly experienced nursing professional, you will have sound NHS experience, comprehensive understanding of governance and regulatory requirements and the ability to work at Board level.

To find out more and to apply, please visit NHS Jobs quoting reference 293-20114, application by CV and covering letter to Nancy Hallett. For an informal discussion, please contact Chief Executive Nancy Hallett on 020 8510 7244 or the current Chief Nurse & Director of Governance, Pauline Brown on 020 8510 7320.

Closing date: Monday, 16 November 2009.
Visit our website www.homerton.nhs.uk/workforus

The Trust welcomes applications from candidates wishing to job share, with or without job share partners. Committed to Equal Opportunities.

H41420B9

SALARY BAND 8

FINANCIAL CONTROLLER

Salary 8C

Please see our main advertisement in the Band 9 pages.

Queen Victoria Hospital NHS
NHS Foundation Trust

VEREDUS

H41404B8

Senior Management opportunities with a leading independent healthcare provider in the South West.

UKSH

NHS

UK Specialist Hospitals (UKSH) is a leading independent sector healthcare company contracted to deliver elective services to NHS patients. UKSH delivers top quality healthcare, high professional standards and outstanding clinical results for NHS patients. In November 2009, UKSH will be opening three new Treatment Centres in the South West.

We are looking for successful managers with the drive, passion and clinical experience to enable UKSH to deliver high quality patient care and outcomes and join our team of 350 healthcare professionals.

Clinical Effectiveness and Quality Manager

Bristol (Ref – SW064)

Circa £50,000 + Benefits

A senior, strategic role, the successful candidate will take lead responsibility for ensuring clinical effectiveness and quality is achieved through collaborative work with the Senior Management Team and clinical leads across all UKSH Treatment Centres across the South West.

You will ensure effective clinical governance through continuous monitoring and audit of clinical practice and outcomes. With experience from a similar healthcare environment, you will drive continuous effectiveness and quality improvements through regular practice reviews; benchmarking internal analysis against best practice.

Theatre Manager

Bristol (Ref – SW012)

Circa £45,000 + Benefits

A highly motivated and committed leader, you will focus on delivering outstanding patient care by taking responsibility for the management of the pre and post anaesthetic care units (PACU), 7 operating theatres, 2 endoscopy suites and sterile services across all UKSH Treatment Centres across the South West.

An expert clinical practitioner, you will have responsibility for the co-ordinating and delivery of clinical practice for all peri-operative services whilst managing an extensive team of qualified nurses and health care assistants.

Outpatient Manager

Bristol (Ref – SW014)

Circa £33,000 + Benefits

A passionate and driven clinician, you will take responsibility for the management of the Pre–Assessment and Outpatient Departments across all UKSH Treatment Centres across the South West.

With overall responsibility for the delivery of patient care, you will co-ordinate and oversee clinical practice whilst ensuring staff compliance in order to meet required regulatory standards. You will also take ownership of ensuring appropriate action is taken when patients do not meet the inclusion criteria of the treatment centre.

If interested, please send a cover letter and CV to mblythin@uk-sh.co.uk
For more information please call 01454 203781 or visit www.uk-sh.co.uk

Closing date: Monday 9th November 2009

Candidates for the above positions will be subject to the appropriate CRB disclosure.
We are an equal opportunities employer.

www.uk-sh.co.uk

H41414B8

SALARY BAND 8

hsjjobs.com

SALARY BAND 8

hsjjobs.com

NHS
Western Cheshire
Your partner for longer healthier lives

Consultant in Public Health Medicine/Consultant in Public Health - Lead for Health Protection

Ref: 661-WC-1274

Salary: NHS Consultant or NHS Agenda for Change Scale 8D (dependent on experience and qualifications)

NHS Western Cheshire is seeking to appoint a Consultant in Public Health Medicine/Consultant in Public Health to join our Public Health team and lead on health protection. This is an exciting opportunity to develop this new role which has been set up to provide public health leadership for health protection issues with an opportunity to also lead the health contribution to one of the Area Partnerships Boards of the Local Strategic Partnership.

You will provide expert advice and leadership to support commissioning and the development of high quality services across primary, secondary and social care, and work with partner organisations including local authorities and voluntary organisations. You will be responsible for the development, implementation and delivery of national, regional and local policies, developing inter-agency and inter-disciplinary strategic plans and programmes, with delegated Board and organisational authority to deliver key public health targets. You will need to have a high level of credibility within the Primary Care Trust and with partners, and be able to act as the local expert and leader on issues relating to health protection.

You will be employed by NHS Western Cheshire and will work as part of multi-disciplinary teams in the local health community, operating at senior management level, and taking advantage of common priorities and economies of scale where possible.

NHS Western Cheshire was formed in October 2006 and covers a diverse population of over 239,000 including areas of urban deprivation, rural communities, and affluence. We would be keen to discuss the opportunities presented by this post with interested candidates.

For an informal discussion please contact: Julie Webster, Acting Director of Public Health, Western Cheshire Primary Care Trust and Cheshire County Council, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ. Telephone: 01244 650353.

Closing date: 12th November 2009.

Interview date: 26th November 2009.

POSITIVE ABOUT DISABLED PEOPLE

INVESTOR IN PEOPLE

APPLICATION INSTRUCTIONS
To apply please log on to the NHS Jobs website at **www.jobs.nhs.uk** For more information on the Western Cheshire PCT go to **www.wcheshirepct.nhs.uk**

Cheshire HR NHS Service

H41412B8

Forensic Services

Corporate Services

Local Services

Crowthorne, Berkshire

Consultant Nurse

Band 8b £49,812 - £60,268 p.a. (dependent on experience and qualifications)

37.5 hours per week

We are looking for a dynamic and creative individual with passion and drive for improving mental health services to take on the role of Consultant Nurse at Broadmoor Hospital.

Broadmoor Hospital in Berkshire provides mental health services in conditions of high security with well-established academic links to a number of universities. The Hospital is at the forefront of change in forensic mental health, provides a wide range of therapies and rehabilitation services and expert forensic assessments in collaboration with the criminal justice system and other health care providers. Broadmoor Hospital is currently progressing a significant redevelopment agenda with the focus on providing the best possible, recovery focused, clinical care.

The Consultant Nurse will work with the Service Director and Clinical Lead to advance evidence-based practice and to provide robust clinical leadership and service improvements within a specific directorate. The Consultant Nurse will provide visible professional leadership to all nurses within the service and work with the Deputy Director of Nursing in providing nursing governance including leadership, professional regulation, learning and development and quality activity.

Fifty percent of the Consultant Nurse's time will be spent in clinical practice. You will need to demonstrate an advanced level of clinical practice with a record of utilising research and audit processes and outcomes to advance practice and service delivery and have completed or be engaged in Masters level study. You will be expected to have a minimum of six years post registration mental health clinical experience with at least two years in forensic mental health nursing. The ability to demonstrate leadership skills, be knowledgeable about the management of change and be able to make a significant contribution to practice-led education, organisational development, teaching, and research activity is also key to this role.

If you are looking for a challenging career and would like to be part of a dynamic team please contact James Noak, Deputy Director of Nursing or Robert Murray, Service Director on telephone number 01344 754 055.

Please apply online at www.wlmhtjobs.nhs.uk or alternatively to request a job pack for this position telephone our recruitment line 020 8354 8122, or email HR-Admin@wlmht.nhs.uk quoting your name, address and job reference number 222-WL7944.

Closing date: Friday 6th November 2009.
Interview date: Friday 20th November 2009.

The Trust will apply for an enhanced CRB disclosure for the successful candidates prior to appointment and welcomes applications from all sections of the community who fulfil the criteria for the post; we're keen to ensure that our workforce reflects the community it serves, particularly in terms of ethnicity, gender, disability and experience of mental illness and committed to equal opportunities and where practicable facilitating flexible working arrangements, to safeguarding all children and vulnerable adults and expects all staff and volunteers to share this commitment. The Trust operates a No Smoking policy for all staff.

West London Mental Health NHS
NHS Trust

Many viewpoints. One vision.

POSITIVE ABOUT DISABLED PEOPLE

H41423B8

NHS

Bournemouth and Poole Community Health Services

Associate Director of Finance and Estates

Band 8d £63,833 - £79,031 per annum
Full Time **Job Ref: 533-687**

Bournemouth and Poole Community Health Services provide a wide range of services across Bournemouth, Poole and to some areas of Dorset. As a provider organisation we wish to deliver excellent services to our local community.

To do this we need to expand our high performing senior team by appointing an individual with significant experience of operating at a senior level within the NHS finance services. Experience of the estates function would be an advantage. You will ensure that all key financial systems are operating effectively and that we meet our corporate financial objectives.

You will need to be self motivated with a demonstrable track record of achievement and delivery of service change. You will have strong leadership skills as well as first class communication skills with an ability to influence key stakeholders.

You will understand the opportunities and challenges open to community services and will be able to work productively with staff and partner organisations to increase our turnover by gaining new business.

We can offer:

- An excellent working environment
- A superb location with easy access to the coast and countryside
- Relocation expenses

Informal discussions are welcome. For further information please contact Valerie Graves, Chief Operating Officer on 01202 541470.

Closing Date: 06/11/2009

www.bournemouthandpoole.nhs.uk

H41406B8

Artwork by Charlie Taylor

LSCB Business Manager

£36,313 – £38,961 Brighton & Hove

In this key role, you'll be an integral part of assisting and progressing the work of the LSCB in ensuring a real positive difference to safeguarding children and young people. With a commitment to achieving the best outcomes, your excellent communication and interpersonal skills will be supported by substantial experience of a multi-agency environment and a good grasp of the local and national safeguarding agenda.

This post is exempt from the Rehabilitation of Offenders Act 1974 and subject to a Criminal Records Bureau Disclosure check.

Apply online now at: jobs.brighton-hove.gov.uk

T 01273 292284 (24-hour answerphone)
E jobs@brighton-hove.gov.uk

Please quote reference CYT15119.
Closing date: 2 November 2009.

We do not accept CVs as part of our recruitment process.
This job is subject to pay and grading review.

WORKING FOR A DiverseCity

NHS | Brighton and Hove Children and Young People's TRUST | Brighton & Hove City Council

H41418B8

Scarborough and North East Yorkshire Healthcare NHS
NHS Trust

Facilities Directorate, Scarborough Hospital

Medical Devices & Decontamination Manager

£44,258 - £54,714 p.a. • Band 8b (Pending Agenda for Change)

37.5 hrs p.w. • Job Ref: 420-S3525

An exciting opportunity has arisen for someone to build upon the solid foundations we have developed to date and be part of the Facilities team that puts patient safety at the heart of everything we do.

As a key leader within the Facilities Directorate, our new Medical Devices and Decontamination Manager will be responsible for the Sterile Services function, Medical Engineering department and our expanding Medical Devices Library Service. You will also have the opportunity to influence key medical equipment investment decisions and be able to help the development of clinical skills training. We have a state of the art and fully compliant sterile services facility and aim to develop our medical engineering service to be best in class. This role therefore offers a significant opportunity to make a major impact in improving our medical devices management and will offer a positive development opportunity for the right candidate.

Applicants must already have significant experience as a medical devices or sterile services manager, with an interest in decontamination, and now be looking for a new and demanding challenge.

Applicants must also have further specialist/technical knowledge of medical devices and/or decontamination; acquired through relevant post-graduate qualifications (e.g. a Masters degree in Biomedical Engineering or Decontamination). Full graduate membership of the Institute of Decontamination Sciences (IDSc) and/or the Institute of Sterile Services Management (ISSM) is essential.

For further information, or to arrange an informal visit, please contact: James D Hayward, Director of Facilities on 01723 342660, or email: james.hayward@acute.sney.nhs.uk

Please apply online at www.jobs.nhs.uk

Closing Date: 5 November 2009.

The Trust is committed to improving your working/home life balance by encouraging flexible working.

Working towards equal opportunities

H41413B8

Salford City Council

Salford NHS
Primary Care Trust

CONSULTANT IN PUBLIC HEALTH/ PUBLIC HEALTH MEDICINE

Share Our Passion for Reducing Health Inequalities

Are you prepared to take on one of the most challenging public health jobs in the country? Salford PCT and Salford City Council have some of the most deprived communities in the country but the City has strong prospects because of the significant regeneration in the area and drive of local partners and local people to make a difference.

Salary Agenda for Change Band 8d or Medical Consultant scale MC72
Hours: Full time (10 PA's) and job share applicants welcome

You will enjoy the challenge of working in new ways in an integrated, busy public health team. We are looking for a dynamic change manager who will lead on public health information, clinical effectiveness and in the reduction of health inequalities.

To ensure integration, this post is a joint appointment with the City Council and the PCT Public Health Directorate.

The portfolio includes:

- Information, Joint Strategic Needs Assessment
- Commissioning, Clinical Effectiveness
- Support to Practice Based Commissioning

For an informal discussion please contact David Herne 0161 212 5693.

Closing date: 31st October 2009.
Interview date: 16th November 2009.

In return we can reward you with family friendly and flexible working policies, a staff counselling service, corporate leisure membership, professional development opportunities and a minimum of 27 days annual leave plus bank holidays.

To apply please log on to www.salford-pct.nhs.uk, click on Jobs then Current Jobs and refer to the appropriate job title and reference number: 608-SM09-35R.

Please ensure that you demonstrate how you meet the essential criteria that are to be assessed at the application stage in the person specification in your personal statement.

The Trust aims to be an equal opportunities employer. Committed to developing a workforce that is representative of the Community of Salford.

H41421B8

NHS Westminster

Polysystem Development Manager

Band: 8B • Salary: £50,338 - £60,794 pro rata, per annum including high cost area supplement • Base: 15 Marylebone Road, London NW1 5JD 37.5 hours per week • Permanent • Ref No: 756-NHSW-0021

NHS Westminster is located in the heart of London serving areas such as Paddington, the West End and Soho, Whitehall and Pimlico. In Partnership with local hospitals and Westminster City Council, the Trust is responsible for the planning and delivering of healthcare in the community and general practice. Together with local clinicians and patients and public, the PCT aims to develop and design a quality service local to Westminster communities.

We are looking for a dynamic, focused individual to make a key contribution to the development of Polysystems in Westminster. The successful individual will work closely with Practice Based Commissioning clusters to plan, design, project manage and deliver sustainable networks of coordinated community services across Polysystems, as well as playing a key role in the work of the PCT Polysystem Programme team as it develops and implements a PCT-wide governance framework for Polysystem working.

Successful candidates will demonstrate:

- The ability to work across a network of projects and programmes in a complex environment
- The ability to delegate, manage a team, and work alone
- Excellent interpersonal and communication skills
- The ability to prioritise and meet deadlines
- Project management experience
- Good organisational skills
- Proven management skills

Informal discussions are welcome by contacting Nicola Jones – Polysystem Programme Manager on 020 7150 8036 or 07827 349499 and/or email nicola.jones@westminster-pct.nhs.uk

In order to apply for this position, please visit www.jobs.nhs.uk and quote the appropriate reference.

◆ ◆ ◆ ◆ ◆ ◆

All NHS employees qualify for membership of the NHS Pension and Life Assurance Scheme. The trust also offers other excellent benefits including award winning training and development programmes and assistance with transport and childcare. Facilities at some sites include a gym and subsidised restaurant. Westminster Primary Care Trust actively promotes equality of opportunity and welcomes applications form all sectors of the community irrespective of sex, race, disability, sexual orientation, religion or beliefs. The trust is committed to flexible working opportunities including job share.

Closing date for applications is 9th November 2009
Interview date is 18th November 2009

WORKING WITH OUR PARTNERS FOR A HEALTHIER WESTMINSTER

NHS Central London Community Healthcare

H41411B8

Southampton NHS University Hospitals NHS Trust

SOUTHAMPTON GENERAL HOSPITAL

WESSEX NEUROLOGICAL CENTRE, NEUROSCIENCES

Theatres Manager

Band 8b, £44,258 – £54,714

Southampton University Hospitals NHS Trust is one of the country's largest teaching hospitals and provides services to its local catchments population of 500,000 people. Its growing tertiary services are provided to a population of three million across the southern counties of England including the Isle of Wight and the Channel Islands.

Taking responsibility for the operational management of Neurotheatres, you'll ensure a high quality and safe service for patients, whilst managing the budget and taking the lead role in achieving key performance targets. You'll lead the theatre workforce and encourage a culture that embraces clinical and professional excellence. You'll also help improve our patient services by contributing to the development of our operational plans.

With senior level experience gained within either the public or private sector, you'll have a track record of success in a complex, multi-site, consumer-facing environment, along with the ability to maximise the opportunities available within a rapidly changing healthcare market.

To arrange an informal visit, please contact Jacqui McAfee, Care Group Manager on 023 8079 6388.

For further information and to apply online, please visit our website www.jobs.nhs.uk searching for job reference number 188-S519.

Closing date: 6th November 2009.

H41601B8

Royal Free Hampstead NHS NHS Trust

Director of Facilities

Band 8d: £69,913 - £85,111 pa (including inner London high-cost area)
Ref: 391-234

A large London acute teaching hospital and founding partner of the UCLP Academic Health Centre, we are proud of the world class standards of clinical care we provide to our patients locally, nationally and internationally.

We are looking to recruit a dynamic Director of Facilities, who has the strategic vision and operational skills to ensure our facilities management standards match our world class clinical and research standards.

Your track record of sustainable success in previous roles and your ability to inspire and lead will set you apart. We need an individual who can think strategically and still be delivery focused, seeing tasks through to conclusion. We have an ambitious agenda which calls for an ambitious leader.

If you would like to discuss this role in further detail please contact Therese Davis, Director of Nursing and Healthcare Governance on 020 73177 520 or Philip Holmes, Director of Facilities and PPI on 020 73177 546.

To apply for this role or for further information about the Trust and other vacancies available visit our website. www.royalfree.nhs.uk

Closing date: 12th November 2009.
Interview date: 25th November 2009.

Applications are welcome from people wishing to job share or work flexible patterns.

Committed to Equal Opportunities.

H41410B8

The Ipswich Hospital NHS
NHS Trust

Women's and Children's Services

General Manager

Band 8C £53,256 - £65,657 p.a.

Ipswich Hospital NHS Trust is one of the largest general hospitals in East Anglia, providing healthcare services to nearly half a million people.

We are looking for an ambitious, energetic and highly motivated individual for the Women's and Children's Services Business Unit.

As a key member of the Business Unit team you will lead and manage staff and non-pay resources to ensure the effective service delivery and day-to-day operational performance of the Business Unit whilst achieving financial, quality, clinical governance and performance targets, together with the delivery of strategic objectives.

If you are committed to delivering better care in the NHS, have a vision for the future of healthcare, are able to drive change and enjoy working in a dynamic and evolving service, then we look forward to receiving your application.

For further information please contact Stephanie Preston, General Manager on 01473 703266.

To apply please visit www.jobs.nhs.uk or telephone 01473 704167 quoting post number 269-09.

Closing date: 4 November 2009.
Interview date: 20 November 2009.

Flexible working practices available
Day care nursery facilities
Committed to equality and diversity

MINDFUL EMPLOYER

POSITIVE ABOUT DISABLED PEOPLE

H41602B8

TENDERS

Radiology/Ultrasound Service
Harold Wood Polyclinic

NHS Havering invites Expressions of Interests from all suitably qualified and experienced healthcare providers to supply:

- The final fit-out of the X-Ray suite – including Digital X-Ray equipment
- The final fit-out of the Ultrasound suite – including Ultrasound equipment
- The staff to supply the services
- Approximately 6000 patient episodes per year

Service commencement will be Spring 2010 with initial contract duration of 3 years.

The service will operate in a suite of rooms which are 39.9 sq m. for the X-Ray/Process rooms and 12.4 sq m. for the Ultrasound area. Changing rooms and office space will also be provided.

Those wishing to submit an Expression of Interest (EOI) are asked to do so by the 30th October 2009, by following the link and completing the EOI template.

www.havering.nhs.uk

Havering Primary Care Trust : Procurement radiology/ ultrasound service

H41202TEN

East London NHS
NHS Foundation Trust

Tender for the Provision of General Practitioner (GP) and Primary Care Services

East London NHS Foundation Trust are inviting expressions of interest from suitably qualified organisations that can demonstrate the knowledge, innovation and ability to tender for the purposes of becoming a provider to deliver General Practice (GP) and associated Primary Care Services to the Forensic Directorate based at the John Howard Centre in East London.

The Context

The John Howard Centre is a regional medium secure unit, with a large and diverse inpatient population across 14 wards and incorporating a range of specialist services. Patients are admitted from prison, high secure services and from inpatient units when they are unable to manage the risks associated with their illness. A core component of the Directorate's physical healthcare strategy is the provision of primary healthcare services to all inpatients.

The Intervention

The Trusts aim is to establish and develop General Practitioner (GP) and Primary Care Services for inpatients cared for by the Forensic Directorate over the next 5 years that is also responsive to future service developments.

Organisations wishing to tender shall need to demonstrate

- A successful track record of providing GP and associated Primary Care Services, working within the Quality and Outcomes Framework.
- Knowledge and experience of working within the mental health sector or comparable services.
- Partnership working with the commissioner, including the capacity and ability to explore and develop service provision in line with developments in the Forensic Directorate and following reviews of the service provided.

Time Frame

The initial term of the contract will be 3 years with a option to extend for an additional 2 years, it is expected that the successful contractor shall be able to commence provision of the services on 1st April 2010.

Outcome

Organisations that are selected to tender for this contract will be invited to submit tenders in response to the Invitation to Tender document. The contract for the GP and Primary Care Service will be specifically tailored to meet the needs of the Forensic Directorate, regularly reviewed and be time limited with demonstrable outcomes.

To express your interest to tender please submit your expression of interest via email to charmain.elliott@thpct.nhs.uk quoting tender reference 169/ELFT/FOGP/10/09, name of organisation expressing an interest, name of individual to whom further details are to be sent, email address and telephone number of named individual. Should you experience any difficulty emailing Charmain Elliott please call on 020 8223 8915.

Closing date for 'Expressions of Interest' is 1200hrs of Thursday 12th November 2009.

A Pre-Qualifying Questionnaire shall be sent to all whom express an interest on *Friday 13th November 2009.*

H41201TEN

TENDERS

SALARY BAND 8

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Earlier this year we opened a Midlands office and due to its success, we are looking for **Senior Consultants, Consultants and Assistant Consultants.**

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for more information go to: www.inventures.co.uk/careers

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OFF DIARY

Fake fake fags

We all know about the dangers posed by cigarettes – but what about fake cigarettes?

The makers of SmokeStiks – which deliver a nicotine hit without the tobacco – have issued a warning about the perils of "cheap imitations".

They urge consumers to beware of inferior copycat products from China that are "nowhere near the same quality" as SmokeStiks, promoted as a "much healthier alternative to conventional cigarettes".

SmokeStiks, the press release boasts, are so good they have a "phenomenal" celebrity following including Kate Moss, Sarah Harding and Rhys Ifans – all huge advocates of the healthy lifestyle, we're sure.

● End Game is always quick to point out the gaffes of red faced health managers and policy wonks, so it seems only fair to highlight blunders closer to home.

HSJ was last week contacted by the British Heart Foundation, which was receiving its magazine late each week because it kept being sent to the wrong postcode.

The subscriber kindly provided the correct address – Greater London House, Hampstead Road, London NW1 7EJ.

Rather unnecessary, you might have thought, seeing as we're based in the same building.

● Mike O'Brien, so successful as a junior minister that he has been one almost continuously since 1997, has an unfortunate habit of upsetting civil servants.

So End Game wonders if one was indulging in sweet revenge last week when preparing Mr O'Brien's papers for a parliamentary debate on the health bill.

The minister had just started introducing the government's surprise concession to mental health foundation trusts (allowing them to take private patients) when he had to stop short, explaining his speaking notes were not in order.

"They have just been reorganised, and I think that those who reorganised them did so somewhat more efficiently than they should have," Mr O'Brien told the speaker.

He won't win any popularity prizes for blaming his civil servants for that one either.

● We know things are getting tight for MPs with their weekly cleaning bills capped at just £40 each, but poor health secretary Andy Burnham really seems to be feeling the pinch.

Kerry McCarthy MP – the government's Twitter tsar for those who have not been keeping up – spotted Mr Burnham last Tuesday night being given a push-start in his ministerial car by MP Ian McCartney. Apparently the battery was flat.

● Many NHS staff have spent years lobbying and marching to gain official recognition from regulators, but perhaps they should try running around in circles or catching mice instead.

End Game was surprised to hear about George the cat, who somehow prowled his way onto not one but three separate professional therapists' registers. George's owner, a BBC journalist, managed to dupe the regulators after producing a phoney certificate from the Society of Certified Advanced Mind Therapists.

In a separate development, a farmer in Kirklees has been fined £150 for failing to meet his cow's "psychological needs". As the first accredited therapist of the animal world, perhaps George can lift his miserable moo-d (sorry).

Friesians to be cheerful

MALCOLM WILLETT

CALLY BANN

Ten years at the helm and not a single complaint about car parking. Until the Boy Burnham sticks his nose in, that is.

I accept that we are blessed by the 17 year delay to phase 3 of the site redevelopment and, in particular, by the fact that phase 2 involved the razing to the ground of a Victorian monstrosity with a footprint the size of a 600 strong car park. Which means that the staff and the patients are happy in a fit for purpose facility run by the two most fulfilled car park attendants this side of Timbuktu.

OK, so perhaps they shouldn't be running their allotment shop from there on Thursdays. But hell, it looked good on our declaration on promoting public health – and the beetroot's to die for.

But no longer. Everyone to park free, yells the Boy Burnham, as 150 ex-park and riders dance deliriously around a funeral pyre of bus passes and eye up the best spots for the quick sprint to the 7.56 to Bletchley. (I mean the 9.00 appointment in the eye clinic – honest!) Which makes the staff unhappy, the patients unhappy, and puts the kibosh fair and square on my *betteraves à la crème au noix de saison*.

Desperate times call for desperate measures. Time to unleash the fifth horseman of the apocalypse; to let loose the hounds of hell; to go to the consultants committee. Strategy and policy on the agenda: tumbleweed junction and all the engagement of a Frenchman at a cricket match. Yet when it is car parking there is standing room only and a passion beaten only by the annual post mortem on the clinical excellence awards round.

How should I know that the chairman of the committee happens to be married to the editor of the *Bugle*? Or that the medical director's husband is the prospective MP with a passionate interest in market gardening and encouraging the entrepreneurial spirit that made this county great?

Playing with car parking, Mr Burnham, makes reducing health inequalities look like a stroll in the park. Now, where did I put that recipe for borscht?

NEXT WEEK

Commissioning
You cannot have world class commissioning without world class decommissioning. Find out more in Resource Centre

Money in your hand
The NHS Counter Fraud Service has transformed fraud response – but trusts still struggle to recover missing money

HSJ online
Check out hsj.co.uk for the latest breaking news, comment and blogs and best practice advice from Resource Centre

NHS
National Institute for
Health and Clinical Excellence

NICE helps in more ways than you think...

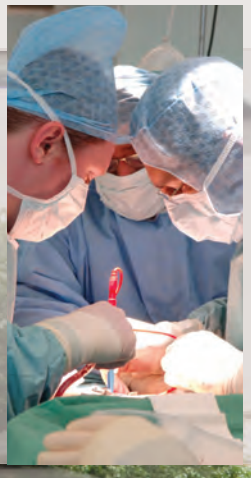
NICE guidance sets the standard for good healthcare

Public health guidance is sent to local authorities and other public organisations to ensure that public services improve the health and wellbeing of our communities.

Clinical guidelines provide guidance on the care and treatment of people being looked after in the NHS.

Technology appraisals guidance informs the NHS about when and under what circumstances drugs and other technologies should be prescribed.

Interventional procedures guidance informs the NHS about when and under what circumstances certain surgical procedures should be offered.



Online guidance tools

Generic and guidance-specific online tools are available on the NICE website to help the NHS and the public health sector implement NICE guidance.

Generic implementation tools include:

- forward planner
- audit advice
- how NICE guidance can help you achieve Local Area Agreement targets

Guidance-specific implementation tools include:

- costing tools
- slide sets
- education tools

Quality initiatives

NICE is also taking on a new role to help improve quality in the NHS by:

- Setting quality standards
- Advising on indicators for the Quality and Outcomes Framework
- Developing a fellowship programme to reward contributions to quality care

www.nice.org.uk